



Aalborg Universitet

AALBORG UNIVERSITY
DENMARK

Outcomes and Processes of the Bonny Method of Guided Imagery and Music (GIM) and its Adaptations and Psychodynamic Imaginative Trauma Therapy (PITT) for Women with Complex PTSD

Maack, Carola

Publication date:
2012

Document Version
Early version, also known as pre-print

[Link to publication from Aalborg University](#)

Citation for published version (APA):
Maack, C. (2012). *Outcomes and Processes of the Bonny Method of Guided Imagery and Music (GIM) and its Adaptations and Psychodynamic Imaginative Trauma Therapy (PITT) for Women with Complex PTSD*.

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal -

Take down policy

If you believe that this document breaches copyright please contact us at vbn@aub.aau.dk providing details, and we will remove access to the work immediately and investigate your claim.

**Outcomes and Processes of the Bonny Method of Guided Imagery and Music
(GIM) and its Adaptations and Psychodynamic Imaginative Trauma Therapy
(PITT) for Women with Complex PTSD**

Carola Maack

Thesis submitted for the degree of Doctor of Philosophy

Supervisors:
Prof. Tony Wigram,
Prof. Lars Ole Bonde, and Prof. Cathy McKinney

**Doctoral Program of Music Therapy
Department of Communication and Psychology
The Faculty of Humanities
Aalborg University
Denmark
2012**

Declaration:

I confirm that this thesis and the research it presents has not previously, in part or in its entirety, been submitted for examination at an academic institution of higher education in Denmark or abroad.

Date

Carola Maack

Abstract

With the aim of investigating the roles and use of recorded music in psychodynamic trauma therapy for women with Complex Posttraumatic Stress Disorder (PTSD), this study combines an empirical outcome study with heuristic research. The study focuses on the patient perspective.

To investigate whether the use of recorded music enhances therapy outcome in psychodynamic trauma therapy for women with Complex PTSD, outcome measures of four groups of patients ($n = 34$ per group) were compared. One group of patients received 50 hours of outpatient trauma therapy with the Bonny Method of Guided Imagery and Music (GIM) or its adaptations, another group received 50 hours of outpatient trauma therapy with Psychodynamic Imaginative Trauma Therapy (PITT). The third group was a waiting-list control group of women who had to wait at least nine months for a therapy place, and the fourth group was a separate but matched follow-up group of women who had finished their trauma therapy with GIM at least one year prior to filling out the questionnaires. The participants of the PITT group and the GIM treatment group filled out the Self-Report Inventory for Disorder of Extreme Stress (SIDES-SR), the Dissociative Experiences Scale (DES-T), the Somatoform Dissociation Questionnaire (SDQ-5), the Inventory of Interpersonal Problems for Personality Disorders (IIP-PD25), and the Sense of Coherence Scale (SOC-13) before treatment, after 25 therapy hours, and after 50 therapy hours. The participants of the control group filled out the questionnaires before and after waiting, and the participants of the follow-up group only once. Results showed significant differences in all scores when either of the treatment conditions was compared to the control group. Participants treated with GIM showed significantly better outcome in all measurements than participants treated with PITT. The follow-up group showed significantly better results in the SIDES-SR than the treatment group after 50 hours of therapy. No significant differences were found on any of the other

measurements when comparing the follow-up group and the GIM treatment group at posttest.

For the qualitative part of the study, interviews were conducted with five participants from the PITT group and four participants from the GIM groups with the aim of reflecting the roles of music and imagery in psychodynamic trauma therapy. I also included reflections on my personal experiences as a traumatized patient who had received GIM therapy. Interviews and reflections revealed that music in GIM can be a teacher, a keeper of knowledge or abilities; model different kinds of relationship; be a space for different experiences; represent dissociated parts; bring or evoke imagery, and be a connection with beauty and non-violent parts of the world. Music can also be perceived as a helping being.

Imagery can be used for learning, as connector, and as resource for coping with trauma in everyday life both in GIM and in PITT. However, in PITT the focus in these areas is strictly on calming oneself and on resources, while in GIM the focus is broader. In GIM imagery also is used as form, as space between patient and therapist, as a way of speaking, and as a help to focus.

The results of the study indicate that both GIM and PITT have the potential to significantly improve symptoms of Complex PTSD and dissociation, alleviate interpersonal problems, and enhance factors that promote health in severely traumatized women. GIM and its adaptations were significantly more helpful than PITT. This may be due to the use of music and/or to the more individualized practice of GIM. Music in imagery-based trauma therapy can be used as self-object, and it also offers forms of vitality that may be used by traumatized patients for healing.

Acknowledgements

This project would not have been possible without the support of many people. I would like to say thank you to:

- My doctoral supervisors Lars Ole Bonde who encouraged me to embark on this journey of writing a doctoral dissertation many years ago, and who in his calm and supportive way was there throughout the process with me like a big and supportive container; Tony Wigram who inspired me with his enthusiasm, good humor, and great knowledge, and who died way too early; and Cathy McKinney who willingly and without hesitation became my new supervisor in the middle of the process, who was diligently there whenever I needed help, and who taught me statistics, correct APA-style, and better English.
- The research participants who were willing to share their experiences on the path of healing from trauma, and without whom this project would not have been possible, and their therapists who helped with the organization in the background.
- The European Network GIM (ENGIM), the Association for Music and Imagery (AMI), and Luise Reddemann who helped me to get in contact with participating therapists.
- Märith Bergström-Isaacson, Lars Ole Bonde, E. Christian Buhrmester, Bolette Daniels Beck, Inge Nygaard Pedersen, Inken Prytulla, and Melanie Voigt who helped me with translations into Danish, English, German, and Swedish, and who made international communication with participants from all the different countries possible.
- Aalborg University and the Andreas-Tobias-Kind-Foundation (Hamburg) for their financial support of the research project and of my learning.
- The group of PhD-students and the teachers in the PhD-program at Aalborg University for good discussions, valuable feedback, and a lot of fun during the process.

- All professionals and friends who were there for me on my path of healing in the areas of body, psyche, and spirit, and without whom I never would have had the strength to ever write a dissertation.
- My partner Christian Buhrmester who had walked the path of PhD-studies before me for sharing good discussions, creative thinking, good chocolate, quiet meditations, and play, and who made sure that I did not neglect my inner children too much during times of writing.
- Friends and family members for helping me to find a good balance between work and play, and who believed in me throughout this project.

Table of Contents

Abstract	iii
Acknowledgements	vi
Table of Contents	viii
List of Tables	xii
List of Figures	xv
CD-ROM Contents (Appendix).....	xvi
1. INTRODUCTION.....	1
2. LITERATURE REVIEW	4
2.0 Introduction	4
2.1 Complex Posttraumatic Stress Disorder.....	4
2.1.1 Definition of Psychological Trauma.....	4
2.1.2 Description of Complex Posttraumatic Stress Disorder (Complex PTSD)	5
2.1.3 Dissociation	8
2.1.4 Relationships and Attachment	11
2.1.5 Affect Regulation.....	12
2.1.6 Comorbidity	13
2.1.7 Differential Diagnosis	14
2.2 Influences and Therapeutic Treatments of Complex PTSD	16
2.2.1 Risk Factors and Protective Factors	16
2.2.2 General Aspects of Trauma Therapy for Patients with Complex PTSD	19
2.2.3 Gender Issues in Traumatization and Trauma Therapy	26
2.2.4 Prognosis	27
2.2.5 Posttraumatic Growth	28
2.3 GIM and its Adaptations	30
2.3.1 Description of the Bonny Method of Guided Imagery and Music (GIM)	31
2.3.2 Adaptations of GIM	33
2.3.3 The Role of Music in GIM and its Adaptations.....	34

2.3.4 The Role of Imagery in GIM and its Adaptations	37
2.3.5 The Role of the Therapist in GIM and its Adaptations	38
2.3.6 Pivotal Moments in GIM.....	42
2.3.7 Practice of GIM and its Adaptations with Traumatized Clients	43
2.4 Psychodynamic Imaginative Trauma Therapy (PITT)	45
2.4.1 Description of PITT	45
2.4.2 The Role of Imagery in PITT	47
2.4.3 The Role of the Therapist in PITT	48
2.5 Conclusion	50
3. METHODS	51
3.1 General Description of the Study.....	51
3.1.1 Operational Definitions.....	52
3.1.2 The Use of GIM and its Adaptations in this Study	52
3.1.3 Naturalistic Setting	54
3.1.4 General Aspects of Research in the Field of Psychotrauma	54
3.1.5 Research from the Clients' Perspective	56
3.2 The Quantitative Part of the Study	57
3.2.1 Research Participants.....	57
3.2.2 Therapists and Therapy	60
3.2.3 Quantitative Measurements	64
3.2.4 Hypotheses	67
3.3 The Qualitative Part of the Study.....	69
3.3.1 Heuristic Research.....	69
3.3.2 Qualitative Methodology	73
3.3.3 Participants and Collection of Data.....	75
3.3.3.1 Participants from the GIM Groups	76
3.3.3.2 Participants from the PITT Group	77
3.3.4 Researcher's Context	79
3.4 Ethics	81
4. RESULTS.....	83
4.0 Introduction	83

4.1 Results of the Quantitative Investigation	83
4.1.1 Introduction	83
4.1.2 Effects of GIM and PITT Treatment Compared to the Control Group	84
4.1.2.1 Distribution of Data, Matching of Groups and Covariates	84
4.1.2.2 Effects on Symptoms of Complex PTSD: SIDES-SR	89
4.1.2.3 Effects on Dissociation: DES-T and SDQ-5.....	95
4.1.2.4 Effects on Interpersonal Problems: IIP-PD25	101
4.1.2.5 Effects on Sense of Coherence: SOC-13	106
4.1.3 Long-term Effects of GIM Treatment	109
4.1.3.1 Matching of Groups and Covariates	110
4.1.3.2 Effects on Symptoms of Complex PTSD: SIDES-SR	111
4.1.3.3 Effects on Dissociation: DES-T and SDQ-5.....	115
4.1.3.4 Effects on Interpersonal Problems: IIP-PD25	117
4.1.3.5 Effects on Sense of Coherence: SOC-13	119
4.1.4 Summary of Results.....	120
4.2 Results of the Qualitative Investigation	121
4.2.1 Introduction	121
4.2.2 Reflections on my Personal Therapy Process	122
4.2.2.1 Music.....	123
4.2.2.2 Imagery	131
4.2.2.3 Therapeutic Relationship	135
4.2.4 Results from the Interviews.....	139
4.2.4.1 Music.....	139
4.2.4.2 Imagery	142
4.2.4.3 Therapeutic Relationship	148
4.2.4.4 General Aspects.....	153
4.2.5 Two Individual Depictions	155
4.2.5.1 Individual Depiction of a Participant with GIM Experience	156
4.2.5.2 Individual Depiction of a Participant with PITT Experience	160
4.2.6 Creative Synthesis	163
5. DISCUSSION	166

5.1 Findings	166
5.1.1 The Efficacy of GIM and PITT in the Treatment of Complex PTSD	166
5.1.2 Music and Imagery in GIM and PITT for Women with Complex PTSD	168
5.1.3 General Characteristics of the Treatment of Women with Complex PTSD	171
5.2 Findings in Relation to Previous Research.....	174
5.2.1 The Overall Efficacy of GIM in the Treatment of Complex PTSD.....	174
5.2.2 The Overall Efficacy of PITT in the Treatment of Complex PTSD.....	176
5.2.3 Findings Related to the Theoretical Basis	177
5.2.3.1 The Therapeutic Relationship and General Aspects of Trauma Therapy	177
5.2.3.2 Theory of PITT	183
5.2.3.3 Imagery in GIM and its Adaptations in Trauma Therapy	185
5.2.3.4 Music in GIM and its Adaptations in Trauma Therapy	188
5.2.3.5 Adaptations of GIM in Trauma Therapy.....	191
5.3 Limitations.....	193
5.3.1 Limitations Inherent in the Research Design	193
5.3.2 The Researcher's Own Therapy Allegiances	193
5.3.3 Differences in the Participants' Nationalities.....	195
5.3.4 Moustakas' Heuristic Research	198
5.4 Applications of the Findings.....	198
5.4.1 Clinical Applications	198
5.4.2 Implications for GIM Training	199
5.4.3 Applications for PITT Training.....	200
5.5 Directions for Future Research.....	200
5.6 Conclusion	202
ENGLISH SUMMARY	205
DANSK RESUMÉ.....	219
REFERENCES.....	234

List of Tables

Table 2.1 Countertransference Reactions.....	25
Table 2.2 Differences between Male and Female Victims.....	27
Table 2.3 Levels of Therapy with Music and Imagery.....	44
Table 3.1 Medication and Hospitalization during Therapy or Waiting.....	59
Table 3.2 Waiting Time for Therapy per Group.....	62
Table 4.1 Perpetrator Contact during Therapy by Group.....	85
Table 4.2 Nationalities of Participants.....	86
Table 4.3 Results of Questionnaires at Pretest.....	87
Table 4.4 Academic Degrees of Participants.....	88
Table 4.5 Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress by Group.....	89
Table 4.6 Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale "Alterations in Regulation of Affect and Impulses" by Group.....	90
Table 4.7 Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale "Amnesia and Dissociation" by Group.....	91
Table 4.8 Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale "Alterations in Self-Perception" by Group.....	92
Table 4.9 Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale "Alterations in Relations with Others" by Group.....	93
Table 4.10 Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale "Somatization" by Group.....	93
Table 4.11 Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale "Disruptions in Systems of Meaning" by Group.....	94
Table 4.12 Means, Standard Deviations, Pre-Post Correlations, and Effect Size for Scores on the Dissociative Experiences Scale Taxon by Group.....	96
Table 4.13 Medians and Ranges for Scores on the Dissociative Experience Scale Taxon by Group.....	97
Table 4.14 Means for Scores on Dissociative Experience Scale Taxon Compared to Reference Groups.....	97
Table 4.15 Percentages above Cut-Off Scores of the Dissociative Experience Scale Taxon.....	98

Table 4.16 Means, Standard Deviations, Pre-Post Correlations, and Effect Size for Scores on the Somatoform Dissociation Questionnaire by Group	99
Table 4.17 Medians and Ranges for Scores on the Somatoform Dissociation Questionnaire by Group.....	100
Table 4.18 Percentages above Cut-Off Scores of the Somatoform Dissociation Questionnaire	100
Table 4.19 Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders by Group	10 Fejl! Bogmærke er ikke defineret.
Table 4.20 Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Interpersonal Sensitivity” by Group.....	102
Table 4.21 Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Interpersonal Ambivalence” by Group	103
Table 4.22 Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Aggression” by Group	104
Table 4.23 Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Need for Social Approval” by Group	104
Table 4.24 Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Lack of Sociability” by Group	105
Table 4.25 Means, Standard Deviations, Pre-Post Correlations, and Effect Size for Scores on the Sense of Coherence Scale by Group	106
Table 4.26 Medians and Ranges for Scores on the Sense of Coherence Scale by Group	107
Table 4.27 Percentages of Participants below and above Average of Scores on the Sense of Coherence Scale	108
Table 4.28 Mean Scores on the Sense of Coherence Scale per Group Compared to Percentage of Women in Schumacher and Brähler’s Study below that Mean Score	109
Table 4.29 Distribution of Participants’ Nationalities per Group	110
Table 4.30 Perpetrator Contact.....	110
Table 4.31 Marital Status	11 Fejl! Bogmærke er ikke defineret.
Table 4.32 Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress by Group – Long-Term Effects.....	112
Table 4.33 Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Regulation of Affect and Impulses” by Group – Long-Term Effects	112
Table 4.34 Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Amnesia and Dissociation” by Group – Long-Term Effects.....	113
Table 4.35 Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Alterations in Self-Perception” by Group – Long-Term Effects.....	113
Table 4.36 Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Alterations in Relations with Others” by Group – Long-Term Effects	114
Table 4.37 Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Somatization” by Group – Long-Term Effects.....	114

Table 4.38 Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Disruptions in Systems of Meaning” by Group – Long-Term Effects.....	115
Table 4.39 Means and Standard Deviations for Scores on the Dissociative Experiencing Scale Taxon by Group – Long-Term Effects.....	116
Table 4.40 Means and Standard Deviations for Scores on the Somatoform Dissociation Questionnaire by Group – Long-Term Effects.....	116
Table 4.41 Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders by Group – Long-Term Effects.....	117
Table 4.42 Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Interpersonal Sensitivity” by Group – Long-Term Effects	117
Table 4.43 Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Interpersonal Ambivalence” by Group – Long-Term Effects...	118
Table 4.44 Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Aggression” by Group – Long-Term Effects.....	118
Table 4.45 Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Need for Social Approval” by Group – Long-Term Effects.....	119
Table 4.46 Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Lack of Sociability” by Group – Long-Term Effects.....	119
Table 4.47 Means and Standard Deviations for Scores on the Sense of Coherence Scale – Long-Term Effects	120
Table 4.48 Therapeutic Relationship in Regressed and Transpersonal States.....	138
Table 5.1 Roles of Music and Imagery in GIM and PITT	169
Table 5.2 Enmeshed and Distanced Therapeutic Attitudes and Behaviors.....	182
Table 5.3 Indication of GIM and its Adaptations at Different Levels of Flashback and Trauma Reaction Intensity	192
Table 5.4 Cultural Dimensions and Psychotherapy for PTSD	196

List of Figures

Figure 2.1 Obstructing Countertransference Reactions	24
--	----

CD-ROM Contents

Informed consent and consent forms for the qualitative and the quantitative part of the study in different languages

Ethics Approval

Individual Depictions

Interview Guideline

Letters for the research participants in different languages

Letters for the participating therapists in different languages

Questionnaires in different languages

SIDES-SR

DES-T

SDQ-5

IIP-PD25

SOC-13

Chapter 1: INTRODUCTION

When I started with this study, I already was a trained psychotherapist specialized in trauma therapy, music therapist, and a primary trainer for the Bonny Method of Guided Imagery and Music (GIM). But I was also a trauma survivor who had some years of personal therapy with GIM and other therapy methods with different therapists because of Complex PTSD. I always was a person who got sudden strong intuitions about what was good and helpful for me at a certain time and what was not. This was also my path to this study. Two experiences stood out for me:

The first experience happened in the early 90s when I had just moved to the States and started studying music therapy after having finished my studies of Baroque flutes in the Netherlands. At that time I went to my first music therapy conference which took place in Canada. At the conference I heard Laurie Rugenstein present a GIM case study. For me it was immediately clear that I wanted to learn this method, and that I wanted it included into my personal therapy. I was especially drawn to it because of its world view which included many psychodynamic and humanistic schools of psychotherapy but also did not leave out the transpersonal and spiritual dimensions. Buddhist and yogic meditation had become a strong resource for me during the years I spent in the Netherlands, and I did not want to exclude talking about this practice from my personal therapy. Also as a therapist I wanted to practice a kind of therapy that went with my own world view. The other thing that really drew my interest to GIM was its openness, the attitude that the inner wisdom together with music and imagery would bring up implicit knowledge that could guide patients' paths and also my own path to healing. It gave me and also my future patients a freedom that perpetrators never would allow.

The second crucial experience was during my GIM therapy with therapist B (see Chapter 4) about ten years later. I had worked a lot in therapy, but some things were still

difficult. The symptom that was most disturbing to me was freeze-states which I always got when I had a feeling that a situation might be dangerous. These freeze-states cannot easily be seen from the outside, but they made it completely impossible for me to bring myself into safety on time in situations that really contained possible threats and were not just flashbacks. I never even got the faintest idea of what to do about them, but with the help of a very well trained and empathic trauma therapist, GIM and a lot of patience and creativity, I finally was able to get rid of them – in my eyes: make the impossible possible.

At that time I had also seen many of my traumatized patients and patients of supervisees get better with the help of GIM. I wanted to know what music could contribute to imagery-based psychodynamic trauma therapy. And so the idea for my research was born. It is a study into which I could not only include much of my knowledge as a professional but also my felt inner knowledge as a person who had developed Complex PTSD after prolonged traumatizations and as a patient in trauma therapy.

The aim of this study is to compare the outcome of the Bonny Method of Guided Imagery and Music (GIM) and its adaptations with Psychodynamic Imaginative Trauma Therapy (PITT) as developed and described by Reddemann (2004) for adult patients with Complex PTSD with or without comorbidity from the client perspective. GIM and PITT are very similar (see Chapter 2). One big difference, however, is the use of recorded music in GIM. Comparing both methods might contribute to clarifying the following questions:

1. Is GIM, PITT, or both of these methods indicated for severely traumatized women?
2. When would GIM and when would PITT be indicated?
3. What are different roles of music in imagery-based trauma therapy?
 - a) What could music be particularly helpful with?
 - b) Are there limitations in the use of music?
4. What are characteristics of the treatment of women with Complex PTSD?

Many studies have been done with patients with simple PTSD without comorbid disorders (see for example Foa & Meadows 1997, Keane 1998). However, comorbidity with PTSD is seen in up to 80% of the patients (Reddemann, 2004, p. 146), and I believe that

the prevalence of Complex PTSD – which at the moment is still unknown due to being an unofficial diagnosis – is much higher than the prevalence of simple PTSD. Not much research was done with this group of patients. This study could show some characteristics in the treatment of these patients.

The study focuses on the clients' perspective and uses mixed methods for answering the research questions. Quantitative measures are taken for looking at outcome and comparing outcome of the different therapy methods. Standardized questionnaires allow for empirical research while still staying with the clients' perspective. Qualitative data is taken and analyzed in a heuristic way to further look at qualities of the therapy processed – music, imagery, the therapeutic relationship – as perceived by the research participants including my own experiences. Qualitative data may also further elaborate and clarify on the outcome-measures from the quantitative part of the study. Heuristic research is a reflective method. It gives a subjective perspective and draws a picture of the inner truth of the research participants.

Chapter 2: LITERATURE REVIEW

2.0 Introduction

The aim of the literature review is to explore the existing literature on Complex Posttraumatic Stress Disorder (Complex PTSD), the Bonny Method of Guided Imagery and Music (GIM) and related music and imagery techniques, and Psychodynamic Imaginative Trauma Therapy (PITT) as developed by Luise Reddemann. The first part covers a general description of Complex PTSD, typical comorbidity and problems of differential diagnosis, as well as risk factors and protective factors, and specifics of general psychotherapeutic treatment of patients with Complex PTSD. The second part gives a general description of GIM and its adaptations including the role of the music, the imagery, and the therapeutic relationship. It then proceeds to the literature on practice of GIM and its adaptations with traumatized clients. The third part describes PITT with an emphasis on the role of imagery and of the therapeutic relationship.

2.1 Complex Posttraumatic Stress Disorder

2.1.1 Definition of Psychological Trauma

Psychological trauma is defined in the DSM-IV (American Psychiatric Association, 1994) as

1. “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2. the person’s response involved intense fear, helplessness, or horror”
(American Psychiatric Association, 1994, p. 209).

Fischer and Riedesser (1999) define it in a more conflict-oriented way as "vitales Diskrepanzerlebnis zwischen bedrohlichen Situationsfaktoren und den individuellen Bewältigungsmöglichkeiten, das mit Gefühlen von Hilflosigkeit und schutzloser Preisgabe einhergeht und so eine dauerhafte Erschütterung von Selbst- und Weltverständnis bewirkt."¹ (Fischer & Riedesser, 1999, p. 351)

2.1.2 Description of Complex Posttraumatic Stress Disorder (Complex PTSD)

Complex PTSD was first described by Herman (1998). Her model concentrates on multiple traumatizations over a prolonged period of time and its consequences for the victim. It includes some areas that are not included in PTSD, such as dissociative experiences, interpersonal difficulties, and loss of basic assumptions (Hansen, 1999). Other authors call it Disorder of Extreme Stress Not Otherwise Specified (DESNOS) (see for example van der Kolk et al., 2005). Both terms are interchangeably used in the literature. The diagnosis of Complex PTSD is neither included in the DSM-IV (1994), nor in the ICD-10 (1993), however discussions of how to include trauma-related disorders in the diagnostic manuals are still ongoing (see for example Luxenburg et al., 2001).

Herman (1998) describes the need for this diagnosis:

In general, the diagnostic categories of the existing psychiatric canon are simply not designed for survivors of extreme situations and do not fit them well. The persistent anxiety, phobias, and panic of survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not the same as ordinary psychosomatic disorders. Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder. ... Even the diagnosis of "post-traumatic stress disorder", as it is presently defined, does not fit accurately enough. The existing diagnostic criteria

¹Translation: "... a vital experience of discrepancy between threatening factors of the situation and the individual possibilities for coping with accompanying feelings of helplessness and abandonment without protection, which in turn permanently shakes the view of self and the world."

for this disorder are derived mainly from survivors of combat, disaster, and rape. In survivors of prolonged, repeated trauma, the symptom picture is often far more complex. Survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity. Survivors of abuse in childhood develop similar problems with relationships and identity; in addition, they are particularly vulnerable to repeated harm, both self-inflicted and at the hands of others. (Herman, 1998, p. 118 f)

Herman (1998) describes the syndrome as follows:

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples include also those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.
2. Alterations in affect regulation, including
 - persistent dysphoria
 - chronic suicidal preoccupation
 - self-injury
 - explosive or extremely inhibited anger (may alternate)
 - compulsive or extremely inhibited sexuality (may alternate)
3. Alterations in consciousness, including
 - amnesia or hypermnesia for traumatic events
 - transient dissociative episodes
 - depersonalization/derealization
 - reliving experiences, either in form of intrusive post-traumatic stress disorder symptoms or in form of ruminative preoccupation
4. Alterations in self-perception, including
 - sense of helplessness or paralysis of initiative

- shame, guilt, and self-blame
- sense of defilement or stigma
- sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

5. Alteration in perception of perpetrator, including

- preoccupation with relationship with perpetrator (includes preoccupation with revenge)
- unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
- idealization or paradoxical gratitude
- sense of special or supernatural relationship
- acceptance of belief system or rationalization of perpetrator

6. Alterations in relation with others, including

- isolation and withdrawal
- disruption in intimate relationships
- repeated search for rescuer (may alternate with isolation and withdrawal)
- persistent distrust
- repeated failures of self-protection

7. Alterations in systems of meaning

- loss of sustaining faith
- sense of hopelessness and despair (Herman, 1998, p. 121)

Later the category of somatization including digestive system, chronic pain, cardiopulmonary symptoms, conversion symptoms, and sexual symptoms was added (van der Kolk, 2001).

Van der Kolk et al. (2005) found in their field trial with 400 treatment-seeking traumatized persons and 128 community residents that

(a) early interpersonal traumatization gives rise to more complex posttraumatic psychopathology than later interpersonal victimization; (b) these symptoms occur in addition to PTSD symptoms and do not necessarily constitute a separate cluster of symptoms; (c) the younger the age of onset of the trauma, the more likely one is to suffer from the cluster of DESNOS symptoms, in addition to PTSD; (d) the longer individuals were exposed to traumatic events, the more likely they were to develop both PTSD and DESNOS; and (e) although the community sample and the treatment sample had approximately the same prevalence of PTSD symptoms, almost half of the treatment-seeking sample also met criteria for DESNOS, suggesting that DESNOS symptoms, rather than PTSD, may cause patients to seek treatment. (van der Kolk et al., 2005, p. 395)

In the following three sections dissociation, relationship and attachment styles of persons with prolonged early traumatizations, and their problems with affect regulation will be explained in more detail.

2.1.3 Dissociation

Dissociation is defined as a “deficiency in the cohesiveness and flexibility of the personality” (Resch in van der Hart et al., 2006, p. 4). It is a way of organizing information by compartmentalizing an experience. Traumatic memories are stored in separate personality states. “‘Split off’ aspects of the traumatic experiences are typically perceptual or sensory (rather than linguistic) in nature, and are often initially experienced as inexplicable physical sensations that cannot be verbally explained or deconstructed.” (Luxenburg et al., 2001a, p. 377) “Overwhelming psychological trauma, neglect, and stress are established as major causes of dissociation. ... A relationship has been observed between early psychological trauma, dissociation, and attachment disorder, particularly fearful or disorganized attachment.” (Körlin et al., 2004) Excessive and repeated release of stress-hormones does not just cause reactions in the body and brain, but also changes them, resulting in difficulties synthesizing and personifying terrifying experiences (Nijenhuis

et al., 2004; Perry, 1999; van der Kolk, 1994). Dissociative states and also disorganized/fearful attachment (see 2.1.4.) are neurobiologically characterized by hyperarousal of the sympathetic and the parasympathetic nervous-system simultaneously or in rapid succession (Nijenhuis et al., 2004, Schore, 2001). This feels like standing in front of a traffic light that shows red and green at the same time, no traffic signs showing what to do in this case, and the roads being dangerous and very hard to oversee. Others give the symbol of driving a car at full speed and at the same time using full breaking.

Van der Kolk, van der Hart and Marmar (2000) distinguish between different phenomena of dissociation:

1. Sensory and emotional elements of the traumatic experience cannot be integrated into the personal memory and identity. They stay isolated from normal consciousness, cannot be described in a narrative way, but appear as flashbacks, nightmares and intrusive memories.
2. The traumatized person dissociates into an observing self and an experiencing self to further distance himself from the experience. People report a feeling like leaving the body and observing what happens from a distance.
3. The person develops separate distinct identities or personality states, each of them with her own cognitive, affective and behavioral patterns. An extreme example of this is the dissociative identity disorder as described in the DSM-IV.

Nijenhuis et al. (2004) and van der Hart et al. (2006) developed the concept of structural dissociation, a model based both on clinical experience and neurobiology. In this model, trauma causes the personality to split into an emotional part (EP) and an apparently normal part (ANP). The authors explain the emotional part of the personality as

a manifestation of a more or less complex mental system that essentially involves traumatic memories. When traumatized individuals remain as EP, these memories are auto-noetic for the EP, but not for the ANP. The memories can represent kernel aspects of the trauma ..., a complete overwhelming event, or series of such events, and are usually associated with a different image of the body and a rudimentary or

more evolved separate sense of self ... It is important to note that traumatic memories manifested in the EP are very different from processed narratives of trauma ... While narrative memories are verbal, time-condensed, social and reconstructive in nature, traumatic memories are often experienced as if the once overwhelming event were happening here and now. These hallucinatory, solitary, and involuntary experiences consist of visual images, sensations, and motor actions, which engross the entire perceptual field. They are at least subjectively characterized by a sense of timelessness and immutability, and they have no social function ... Although the EP's traumatic memories include reproductive elements, they are not exact replications of overwhelming events. ... When the EP is activated, the patient in that state tends to lose access to a range of memories that are readily available for the ANP. The lost memories typically involve episodic memories ..., but may also include semantic memories ... and even procedural memories ... The field of consciousness of the EP tends to be highly restricted to the trauma as such and to trauma-related affairs. When EPs have evolved ... they may additionally be focused on matters of the current world that fit their experience and identity. In these cases, their procedural, semantic, and episodic memories have been extended to some degree. However, while the EP has synthesized and personified (aspects of) the trauma into its limited range of memories, ... it has failed to integrate current reality to a sufficient extent. This leaves the EP ultimately unable to adapt to present reality. (Nijenhuis et al. 2004, p. 8 ff)

The apparently normal part of the personality is described as follows:

As ANP they have failed to integrate the trauma, either partially or fully, and tend to be more or less engaged in normal life. The ANP is predominantly marked by a range of losses or so-called negative dissociative symptoms ..., such as a degree of amnesia for the trauma and anesthesia of various sensory modalities. The ANP is also characterized by a lack of personification, both with respect to the traumatic memory and with the EP. ... Intrusions of the EP, especially the traumatic memory

that is associated with this part of the personality, interfere with apparent normality.

(Nijenhuis et al. 2004, p. 10 f)

So the EP mainly serves to deal with threatening situations and represents the defensive system. The ANP is managing daily life. In Complex PTSD the EP is divided further with each part managing one or more trauma-related action systems of apprehension, flight, freeze/analgesia, fight, total submission/anesthesia, and recuperation/return of pain sensitivity. The EP might dissociate further into an observing part (feeling out of body, maybe observing the traumatic incident from above) and an experiencing part. In more severe cases, also the ANP might further split into subparts if something in everyday-life needs to be done but would trigger trauma-memories (for example going to the gynecologist when pregnant).

2.1.4 Relationships and Attachment

Most patients with complex PTSD show a fearful and disoriented attachment style which is characterized by:

- Chaotic, frightened, frightening, dissociated and/or disoriented behavior
- Paradoxical injunctions like “come here and go away”
- Lack of internal coherence
- Intrusive emotional memories
- Rapid shifts in states of mind
- Overt trance states in response to stress
- Difficulties with affect regulation

This attachment style can be either caused by repeated interpersonal traumatization early in life or by a primary caregiver with a fearful/disoriented attachment style. The latter is often seen in transgenerational trauma, and it might even be the cause for it. Repeated interpersonal traumatization in early childhood can cause damage to the developing brain. Maturation of the brain is experience-dependent, and these experiences are embedded in

the attachment relationships. If infants develop a fearful/disoriented attachment style it usually stays into adulthood if untreated, and it makes the person vulnerable to a big range of psychiatric disorders. (Nijenhuis et al., 2004; Schore, 2001; Siegel, 1999)

This attachment style makes intimate relationships including a therapeutic relationship very challenging. That is also due to the survivor's "learned association between attachment and (emotional and physical) pain ... Survivors, or dissociated parts who are phobic of attachment, engage in actions that prevent or disrupt relationships, while those that are phobic of attachment loss engage in actions to prevent rejection or abandonment." (van der Hart et al., 2006, p. 279) Communication in relationships often becomes difficult due to sudden flashbacks, trance-states or lack of internal coherence on the part of the survivor. Flooding with unprocessed memories can make it very difficult even to tell the relationship partner what is going on. (Bass & Davis, 1994; Davis, 1991; van der Hart et al., 2006; Herman, 1998; Huber, 1997, 2003)

2.1.5 Affect Regulation

Affect regulation is not an innate capacity, but it is developed during the first years of life. Shore (2001) writes that

the right prefrontal cortex is critical to the processing and regulation of self functions ... During its critical period of maturation in the first two years, prolonged episodes of intense and unregulated interactive traumatic stress induce not only heightened negative affect, but chaotic biochemical alterations that produce a developmentally immature, structurally defective right brain. ...

The right hemisphere, more so than the left, is deeply connected into the limbic system and the sympathetic and parasympathetic components of the [autonomic nervous system], and therefore it plays a predominant role in the physiological and cognitive components of emotional processing ... This ... hemisphere is specialized for neuroendocrine and autonomic activation ..., for the secretion of stress hormones ..., for the human stress response ..., and for controlling the vital

functions supporting survival and enabling the organism to cope with stresses and challenges ... Severe developmental impairments of these right brain structure-function relationships are manifest in inefficient and vulnerable coping mechanisms, and they occur in the attachment pathology of disorganized infants and toddlers (Shore 2001, p. 234 f)

So this and other literature on the neurobiology of trauma (see for example Nijenhuis et al., 2004; Siegel, 1999) show that affect-dysregulation together with dissociation, and a fearful/disorganized attachment style, are results of maladaptive brain-development. Overtly one observes that persons with Complex PTSD

tend to overreact to minor stressors, become easily overwhelmed, appear to have 'extreme' reactions to neutral or mild stimuli, have trouble calming themselves, and may use extreme, self-destructive measures, such as self-injury, drug use, eating disorders, or compulsive sexual activity, in attempts to manage their emotions. They also typically have a great deal of trouble either expressing or modulating their anger ... Such individuals frequently exhibit suicidal preoccupations, either sexual preoccupations, or difficulty modulating sexual impulses, and heightened risk-taking behavior. (Luxenburg et al. 2001a, p. 377)

Inside, persons with Complex PTSD at times of perceived stress feel a mixture of overwhelming emotions that "ultimately coalesce in a dreadful feeling that psychiatrists call 'dysphoria' and patients find almost impossible to describe. It is a state of confusion, agitation, emptiness, and utter aloneness." (Herman 1998, p. 108)

2.1.6 Comorbidity

There are no studies looking at comorbidity in patients suffering from Complex PTSD, however, a number of studies have been done looking at comorbidity in patients with PTSD. It can be assumed that this applies also to Complex PTSD. Van der Kolk et al. (2005) write:

Numerous studies have shown that PTSD consistently co-occurs with other disorders. The National Comorbidity Survey (Kessler et al 1995) found that approximately 84% of people with PTSD had another lifetime diagnosis, with PTSD typically being the primary disorder. ... The Australian National Comorbidity study (Creamer, Burgess & McFarlane 2001) assessed 10,600 individuals and found that 88% of the sample with PTSD had at least one other diagnosis: most commonly major depressive disorder (48%) and alcohol abuse (52%). Of persons with PTSD, 59% had three or more disorders, and 51% (versus 6% of non-PTSD) met criteria for an Axis II diagnosis. In most cases PTSD was the initiating disorder in all comorbid disorders, including personality disorders. The study found that it is rare, even in a community sample, to find pure PTSD and that traumatized individuals present with a variable constellation of depression, anxiety, and somatization. (van der Kolk et al. 2005, p. 396)

According to clinical reports, severely traumatized patients, including patients with Complex PTSD may also show some of the following disorders and symptoms: sexual disorders, sleeping disorders, obsessive-compulsive disorder, anxiety or panic disorder, amnesia, uncontrollable trance-states, chronic pain, chronic weakness of the immune system, eating disorders, and uncontrollable muscle cramps (Herman, 1998; Huber, 2003).

2.1.7 Differential Diagnosis

The National Collaborating Center for Mental Health (2005) lists the following disorders other than PTSD or complex PTSD that may be triggered by a traumatic event: depression, specific phobias, adjustment disorder (usually with less severe stressors), dissociative disorders, neurological damage due to injuries sustained during the events, and psychosis. Complex PTSD may exist comorbidly with any of these disorders.

Van der Kolk et al.'s (2005) study suggest that Complex PTSD usually is found in combination with simple PTSD, however, PTSD is not a necessary precondition for Complex PTSD (Luxenburg et al., 2001a). Patients suffering only from Complex PTSD but not from PTSD show

(a) severe avoidance and suppression of trauma-related memories ... with associated affect numbing and constriction ...; and (b) over-reliance on dissociation as a coping-mechanism and defense against intolerable affect. In these patients, avoidance, numbing, and dissociative symptoms may function over time to mask the overt intrusive symptomatology ... required to meet full criteria for the PTSD diagnosis. Likewise, for trauma patients with severe mental illness, traumatic intrusions may become overshadowed by ... more severe manifestations of psychopathology, including paranoid ideations, persecutory delusions, and ... perceptual disturbance. (Luxenburg et al., 2001a, p. 384)

Luxenburg et al. (2001a) write that differential diagnosis of Borderline Personality Disorder (BPD) and Complex PTSD is very challenging as they are overlapping in many areas.

Whereas chronic affect dysregulation is the hallmark feature of DESNOS, this symptom is secondary to disturbance in identity and relationships with others in BPD. In essence, BPD represents a disorder of attachment, while DESNOS is considered by most leading clinicians and researchers in the field to be better understood as a disorder of self-regulation. (Luxenburg et al. 2001a, p. 385)

In the ICD-10 the diagnosis of "enduring personality changes after catastrophic experience" (F62.0) is classified. This diagnosis basically overlaps with the concept of Complex PTSD, but leaves out some of the categories. It is described as:

1. A definite and persistent change in the individual's pattern of perceiving, relating to and thinking about the environment and the self following exposure of extreme stress.

2. At least two of the following:

- (1) a permanent hostile or distrustful attitude toward the world
- (2) social withdrawal
- (3) a constant feeling of emptiness or hopelessness
- (4) an enduring feeling of being on the edge or being threatened without external cause
- (5) a permanent feeling of being changed or being different from others. (Dilling, Mombour & Schmidt, 1995, p. 235)

Other than in the description of Complex PTSD, the categories of “alterations in consciousness”, “alterations in perception of perpetrator”, and “somatization” are not present at all. The other categories are listed but not to the same extend as in Complex PTSD.

2.2 Influences and Therapeutic Treatments of Complex PTSD

2.2.1 Risk Factors and Protective Factors

There are factors that have either a positive or a negative influence on the recovery process of the traumatized person. However, up to now there is no research mentioning risk factors specifically for Complex PTSD. The factors listed here either determine how likely it is for the traumatized person to develop any kind of disorder due to the trauma, or influence the prognosis if she develops (Complex) PTSD.

Factors that have a positive influence are:

- 1. A good and lasting relationship with at least one primary caregiver (Fischer, 2000).
- 2. Growing up with extended family (Fischer, 2000).
- 3. IQ above average (Fischer, 2000).
- 4. Robust, active, and sociable character (Fischer, 2000; Huber, 2003).
- 5. Social support (youth groups, school, church, etc.) (Fischer, 2000).

6. Reliable and supportive significant other at adult age, especially spouse or partner (Fischer, 2000; Birck, 2001).
7. Reframing of traumatic events, for ex. seeing it as proof for elite status (Fischer, 2000).
8. Employment or self-employed (Birck, 2001).
9. The traumatized person could talk about trauma(s) in therapy and/or with other persons and the trauma is acknowledged (Birck, 2001; Huber, 2003; Tedeschi & Calhoun, 2004a).

Brewin (2003) lists nine risk factors for developing any posttraumatic stress syndrome. They are listed here in order of importance:

1. Lack of social support after the trauma (mentioned also by Huber, 2003)
2. Posttrauma life stress, for example changing schools, moving, destruction of home, financial problems, etc. (mentioned also by Huber, 2003)
3. Trauma severity
4. Other adverse childhood experiences, for example divorce of the parents, accidents, frequent moving, death of one or more significant others, etc.
5. Low IQ
6. Low socioeconomic status
7. Female gender
8. Lack of education
9. Psychiatric history (mentioned also by Huber, 2003)

Factors that have a negative influence mentioned by other authors are:

1. Low socioeconomic status during childhood (Fischer, 2000; Huber, 2003).
2. Family history of psychiatric disorders (Huber, 2003).
3. Missing acknowledgement of trauma by others (Huber, 2003).
4. Breaking off therapy without proper termination initiated by client or therapist (Birck, 2001; Fischer, 2000).
5. Additional traumatization (Birck, 2001; Fischer, 2000; Huber, 2003).

6. Hospitalization and/or use of psychiatric drugs. Birck (2001), however, states that patients who are hospitalized or use psychiatric drugs may be more severely disturbed patients with a poorer prognosis. The negative influence might thus not be related to the hospitalization or the administration of drugs itself.

The following variables can have either a positive or a negative influence, or are variables that influence the nature of recovery without being positive or negative:

1. Fischer (2000) states that therapist gender has a negative influence on treatment outcome if it does not correspond with the patient's preference. In Birck's (2001) research about processing sexual violence during childhood in women in psychotherapy, she found that if the therapist is female the therapy outcome is better.
2. Fischer (2000) and Birck (2001) see prior therapies influencing psychotherapy outcome in a positive way if the patient was satisfied with the prior therapies and in a negative way if the patient was not.
3. In Birck's (2001) research (see above) women who were in therapy for a short time had significantly worse outcome than women who were in therapy for a long time (her subjects were in therapy for 5 – 120 months with a mean of 40 months). Huber (2003) just states that patients with complex posttraumatic stress disorder need very long psychotherapies. Steele et al. (2001) write that towards the end of rather intense therapy, "some patients will be ready to move on and terminate, some will need sporadic contact, and others will need a regular contact with the therapist that is supportive in nature. Each is an option according to the patient's need and level of functioning."
4. The patient's gender has influence on his/her reactions to trauma as well as on the nature of the course of therapy (Huber, 2003; Gahleitner, 2003).

2.2.2 General Aspects of Trauma Therapy for Patients with Complex PTSD

While prolonged exposure is a helpful treatment for patients with simple PTSD, it is by now known to be of no help or even harmful for patients with Complex PTSD, especially as it promotes dissociation and affect dysregulation (see for example Dorrepaal, 2006; Luxenburg et al., 2001b, National Collaboration Centre for Mental Health, 2005). Herman (1998) developed a three-phase model of psychotherapy for patients with Complex PTSD which today is seen as state-of-the-art for any kind of psychotherapy with patients with Complex PTSD (Huber, 2003; Luxenburg et al., 2001b; Reddemann, 2004; Spinazzola et al., 2005; van der Kolk, 2001). The three phases contain (1) stabilization, (2) trauma confrontation, and (3) integration. These phases are not meant to proceed in a linear way, but one moves fluidly back and forth between these stages throughout the therapy-process, and sometimes even within one session (Luxenburg et al., 2001b; Reddemann, 2004). This flexibility in therapeutic intervention is determined in the main by the degree of severity and ego-strength in the traumatized patient.

Kluft, Bloom & Kinzie (2000) describe three groups of traumatized patients:

1. Patients with little comorbidity and good ego-strength. For those patients it is usually difficult to be with the trauma and to integrate it. Trauma exposure with some supportive work is the main focus of therapy.
2. Patients with comorbidity, little ego-strength, and severe and prolonged symptoms of post-traumatic stress disorder (PTSD). The therapy here has more highs and lows, it is longer, and there is more focus on coping strategies and the present situation of the patient. In therapy, there is alteration between supportive and uncovering work. Uncovering work can be done in times when the patient feels better.
3. Patients with very severe and/or chronic PTSD-symptoms, very low ego-strength and/or severe comorbidity. For these patients, trauma exposure often is destabilizing. The therapy has to focus on stabilization and coping with everyday life. Uncovering work is highly destabilizing and therefore not possible.

This offers a general guideline of when to use which phases. It is also noteworthy to see that for the third category of patients only stabilization should be used. Patients may stay in one category or move upwards when therapy progresses or downwards with additional stressors in their lives. But what are the contents of the three phases of therapy?

The stabilization-phase consists of:

- Psychoeducation about trauma
- Learning to care for physical well-being
- Looking at problems and resources in the patient's environment (for example money, employment, partnership, friends, perpetrator-contact or not, daily structures, etc.)
- Building trust with the therapist
- Learning affect-regulation
- Learning to care for oneself
- If necessary: suicide-contract
- Setting and working with boundaries
- Building self-soothing capacities
- Creating support-systems
- Working with the body-image
- Learning to control traumatic material (Luxenburg et al., 2001; Reddemann, 2003)

Trauma confrontation (second phase) should only be done with patients who are sufficiently stable and who do not have any perpetrator-contact anymore (Luxenburg et al., 2001; Reddemann, 2004). Huber (2003) states that only about 50% of the patients with complex PTSD can be stabilized enough to ever do trauma confrontation. On the other hand, the therapist should consider whether the patient really would be damaged by trauma confrontation, or whether the therapist himself is too uncomfortable with the trauma-story of the patient. Elements of trauma confrontation are described by Reddemann (2001):

- Revisiting the traumatic situation within a clearly structured setting with the goal of trauma-integration.
- The patient has the right to make breaks or stop the whole process whenever she wants.
- Using distancing techniques to make the horror more bearable – suffering through unbearable affects over a prolonged time is neither helpful nor necessary.
- Encourage inner comforting.
- Every trauma confrontation should be followed by stabilization.

The third phase of integration is not very different from general psychotherapy. Its elements may be:

- Accepting one's limitations.
- Looking at intimacy and sexuality.
- Working on conflicts (with relationships).
- Exploring connections with other people.
- Understanding the personal and the social dimensions of trauma, and transforming the meaning of the trauma by making it the basis for social action in connection with others.
- Access creativity more fully.
- Developing a sense of oneself other than just as victim. (Luxenburg et al., 2001; Reddemann, 2003)

As mentioned above, many patients with Complex PTSD suffer from dissociation, affect dysregulation, and a frightened/disorganized attachment style. Neurobiologists hold that for reorganizing the structure of the brain the therapist should stay in a secure/autonomous attachment style to serve as a model for the client('s brain) (Schorer, 2001; Siegel, 1999). Siegel (1999) lists the following features of the secure/autonomous attachment style:

- Consistent, sensitive, perceptive, effective, and predictable communication.

- Capacity of the individual to reflect upon the mental state of another person (“feeling felt by the other”).
- It is manifested in words, facial expression, eye-contact, tone of voice, bodily movement, and timing of the response.

The brain seems to be plastic in many areas, and even though the patient’s brain may have adapted to a hostile and traumatizing environment, it can restructure itself in the presence of a secure and sensitive other.

Birck (2001) conducted a study in which she interviewed women who had experiences sexualized violence in childhood about their coping and their experiences with psychotherapy. Her interview partners revealed the following therapist-attitudes or therapy-techniques that were difficult for them:

1. The therapist tries to avoid, minimize the effects of, or doubts the sexual abuse. The interview-partners reported that they would withdraw if this happened.
2. A neutral attitude of the therapist towards the violence, or silence as response to accounts of abuse can be frightening.
3. Having to lie down or not being able to see the therapist in the therapy-session (for example if the therapist is sitting behind the client’s head) can be frightening for clients.²
4. Not acknowledging the ambivalence felt by the clients.
5. Trying to get to the core of the traumas before the therapeutic relationship is stable enough.
6. Not allowing the client the right to withdraw or change the topic if feelings or memories become overwhelming.
7. Asking the client to empathize with the perpetrator.

Therapists who show concern, respect the boundaries of therapy, and at the same time take the side of the victim, make benevolent remarks, take a clear position against abuse,

² This potentially could cause problems when working with GIM. In my practice I let the client decide if she wants to sit or lie down and if she wants to keep her eyes open or close them. I also sit in a way that she could see me whenever she opens her eyes.

inform the clients about abuse and its effects, and explain the effects of the traumas as coping strategies and not as deficits are seen as helpful by the interview-partners.

Fischer and Riedesser (1999) describe transference in trauma therapy as ein Prozess der Wiederaufnahme von Beziehung und ... insofern auf das Trauma bezogen. Übertragung wird als ein Prozess gesehen, traumatisch gestörte Beziehungen wieder aufzubauen. Bei sozialen Traumata ist hier vor allem die Überwindung von Misstrauen und der Wiederaufbau der Fundamente des kommunikativen Realitätsprinzips erforderlich. Ein therapeutisches Arbeitsbündnis wird aufgebaut bzw. gestärkt, wenn der Therapeut die aus der traumatischen Erfahrung stammenden Beziehungstests aushält.³ (Fischer & Riedesser, 1999, p. 192f)

This also implies that patients who have experienced prolonged and repeated interpersonal traumatizations starting in early childhood, and who developed a fearful/disorganized attachment style will transfer this into the relationship with the therapist. The patient usually offers the therapist to relate to him/her as victim, perpetrator, or rescuer, as the patient is used to only crisis-situations. For the therapist it is important to keep an empathic attitude towards the patient. Wilson and Lindy (1999, p. 528) describe the following obstructing countertransference reactions often seen in trauma therapy:

³ Translation: "a process of re-bonding and by that trauma-related. Transference is seen as a process of rebuilding relationships which were disturbed by trauma. Developing trust and rebuilding the basis for the principle of communicative reality are necessary, especially after interpersonal traumatizations. A therapeutic alliance is developed and strengthened if the therapist can stand the relationship-tests that stem from the traumatic experience."

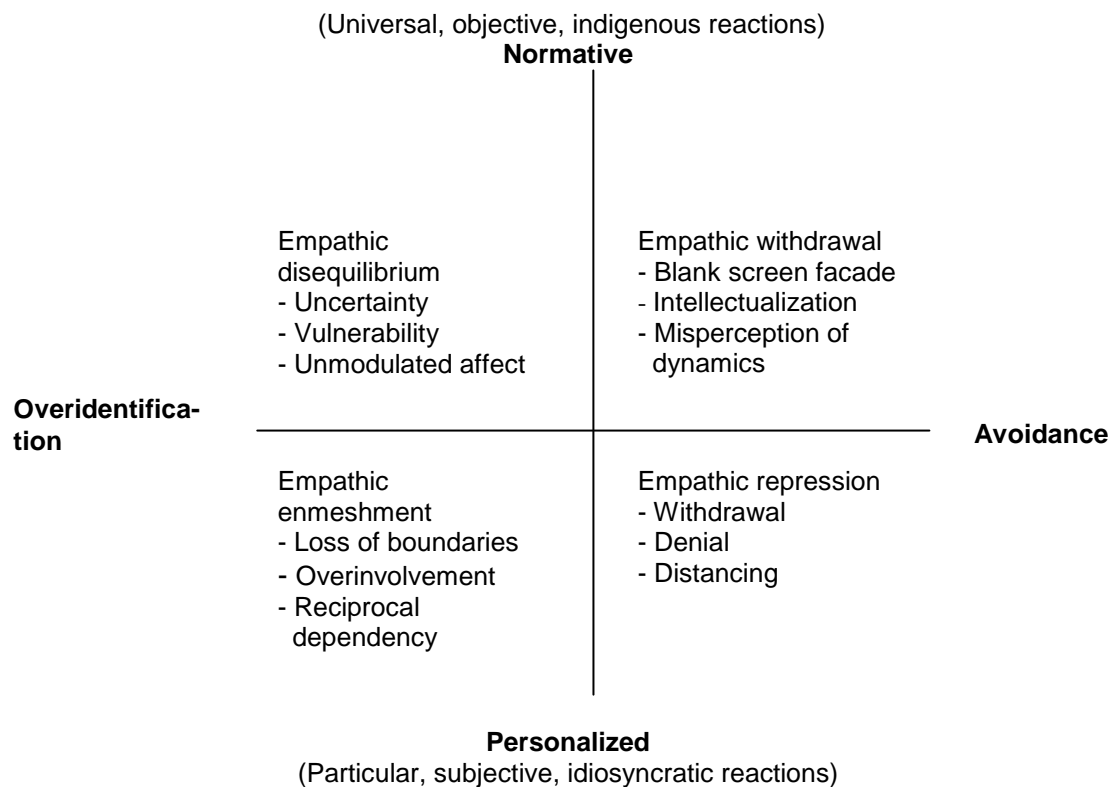


Figure 2.1: Obstructing Countertransference Reactions

Figure 2.1 shows how therapists may leave the optimal position of empathy symbolized by the middle of the cross by over-identifying with the client and by that coming too close to her, or by avoiding the client and her issues and by that taking too big a distance. If a therapist comes too close to the client, he becomes enmeshed, and it might even feel as if he was leading her life. In extreme cases, this may result in vicarious traumatization of the therapist or in the therapist trying actively to control the client's life. Both kinds of countertransference reactions may be more influenced by the individual character of the therapist (personalized), or by cultural influences (normative) which may also include the therapy culture the therapist belongs to.

Steele et al. (2001) and Wilson and Lindy (1994) explain the countertransference positions further. "Enmeshed" in the table below corresponds with "overidentification" in the diagram above and "distanced" corresponds with "avoidance". Both would obstruct therapy. "Balanced" would be the ideal therapeutic position.

Table 2.1: Countertransference Reactions

Enmeshed	Distanced	Balanced
Overidentification	Disavowal and denial of patient's needs	Reflective thinking, consultation, and congruent interpersonal boundaries
Helplessness, hopelessness	Helplessness, hopelessness	Empathy
Attempts to control own internal anxiety by "fixing" patient's need		Non-urgent response to patient's urgency, but with care and empathic attunement to patient's distress
Pity/sympathy	Revulsion, shame, fear, anger	
Unresolved dependency needs of therapist with vicarious satisfaction in meeting patient's needs	Unresolved dependency needs of therapist	
Reflexive response to patient's need in the moment	Intellectualization of therapy	
Boundary violations	Shaming for or preventing patient from expressing needs	
Poor and inconsistent limits	Overly rigid and/or punitive boundaries: excessive limits	Boundary "crossing", i.e. flexible boundaries that are carefully considered and processed before changing
	Reflexive avoidance of patient's need in moment	
Failure to process patient's dependency conflicts	Failure to process patient's dependency conflicts	Empathic attunement with patient
Unable to withstand intensity of patient's demands and appeases	Unable to withstand intensity of patient's demands and withdraws and/or punishes	Awareness of countertransference
Involvement in daily life of patient in concrete ways (e.g. loaning patient money)	Lack of adequate involvement in patient's struggle to live daily life	Allows deep dependency by "caring about" rather than "caring for" patient
Sexualization of dependency	Objectification of dependent patient with sexual exploitation	
Inability to set therapeutic goals regarding dependency	Inability to set therapeutic goals regarding dependency	Separates dependency on therapist in therapy vs. dependency on therapist for daily life
Promotes excessive regression in patient and sometimes in therapist	Promotes excessive independence in the patient and sometimes in the therapist (e.g. not seeking consultation or support)	
Unable to meet patient's needs with therapeutic interventions	Unable to meet patient's needs with therapeutic interventions	Verbally processes dependency issues with patient when appropriate
Inability to distinguish between insecure and secure dependency	Inability to distinguish between insecure and secure dependency	Ability to distinguish between insecure and secure dependency

(From Steele et al., 2001, p. 105)

2.2.3 Gender Issues in Traumatization and Trauma Therapy

Research on gender issues in traumatization and trauma therapy is sparse and highly contradictory. Some authors see no gender-differences at all, while other authors see marked differences with important consequences for therapy. There is consensus, however, that both male and female trauma survivors experience difficulties in affect regulation, amnesia or hypermnesia, dissociation, avoidance, and intrusions (Gahleitner, 2001). The way survivors deal with it or interpret it may differ between men/boys and women/girls.

Gahleitner (2003, 2004) conducted a qualitative study interviewing 18 men and women who are survivors of childhood sexual abuse about the perceived results from the abuse and their coping. She found the following tendencies for men and women (which does not mean that every man and every woman presents this or never presents the tendencies of the opposite gender):

Table 2.2: Differences between Male and Female Victims

	Female Victim	Male Victim
Social back-ground	Society sees her and supports her as victim.	Society sees him and supports him in the role of perpetrator.
Long-term results of the abuse	Psychosomatic, affective, and “internal” symptoms.	Drug and alcohol abuse, conduct disorder, “external” symptoms.
Symptomatic coping	Self-destructive behavior, danger of retraumatization.	Aggressive behavior, danger of identifying with or becoming a perpetrator.
Constructive coping	Controlling their emotions in an instrumental fashion, working on strength, insight.	Expressing emotions.

While women tend to withdraw inwards after traumatizations, men tend to show aggressive behavior against others. Men also tend to self-medicate with alcohol more than women do. While usually women are more able to express their emotions when faced with problems, men are more able to solve problems and look at them in a more intellectual way. However, for trauma-healing both of these coping skills seem to be necessary. This might be the reason why men benefit more from learning to express emotions in therapy while women benefit more from learning to control emotions and working on strength and insight.

2.2.4 Prognosis

Literature on prognostic factors for the treatment of traumatized patients with dissociation was reviewed by van der Hart et al. (2006). In general they report that it “is nearly impossible to engage in effective treatment with patients who continue to live with or are significantly entangled with perpetrators” (van der Hart et al., 2006, p. 236). Apart

from that, they distinguish three groups of patients. Group 1 consists of high-functioning patients with good internal cooperation and empathy, and various social and professional assets. They show little self-destructive behavior, and no comorbidity. These patients respond well to treatment. Group 2 consists of patients with more intrusions of traumatic material, comorbid personality disorders, affective disorders, eating disorders, or substance abuse. They have poor emotional and relational skills. Treatment here is longer and more difficult with crises and possible psychiatric admissions. In group 3, patients with vehement emotions and impulsivity are found. Managing their lives is extremely difficult for them. They tend to have unmanageable dependency or near complete lack of attachment to the therapist. These patients have the poorest prognosis and sometimes manifest negative therapeutic reactions. Looking at these categories, most of the patients in group 1 most probably are diagnosed with (simple) PTSD, while most of the patients from group 3 are most likely to be in-patients. It is anticipated that most patients who will participate in this study belong to group 2 and may or may not have perpetrator contact.

2.2.5 Posttraumatic Growth

Besides all the negative results of traumatization, a number of survivors also report positive life-changes due to trauma, which are systematically researched since the late 80s. Tedeschi and Calhoun (2004a) define posttraumatic growth as “the experience of positive change that occurs as a result of the struggle with highly challenging life crises. It is manifested in a variety of ways, including increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life.” (Tedeschi & Calhoun, 2004a, p. 1) The concept of posttraumatic growth is researched mainly in the area of simple traumatizations, such as bereavement, severe physical disease, coping with medical problems of children, accidents, and house fires; but there is some research also in the area of prolonged and/or early traumatization such as sexual assault and sexual abuse, combat, refugee

experiences, and being taken hostage. Post-traumatic growth is not seen as an alternative to psychological problems after trauma by Tedeschi and Calhoun (2004a), but as a process and product that develops out of trying to cope with the effects of trauma. Negative consequences and growth often coexist. Disclosing the story of the trauma to supportive others can enhance post-traumatic growth. Calhoun and Tedeschi (1999) write that traumatized persons may develop “the ability to balance reflection and action, weight the known and the unknowns of life, be better able to accept some of the paradoxes of life, and to more openly and satisfactorily address the fundamental questions of human existence” (Calhoun & Tedeschi, 1999, p. 21).

Wirtz (2003, 2006) and Wren-Lewis (2004) mention the spontaneous deconstruction of the personality due to trauma and trauma-related out-of-body experiences. This can lead to spontaneous spiritual experiences which the survivor will have to integrate into her life. Those experiences can be very healing in itself, but they can also be very confusing or destructive. Wirtz (2006) writes: “Traumatische Erfahrungen können eine Chance sein, mit einer existentiellen Ebene in Kontakt zu kommen als Tor zur Transzendenz; aber wenn die Heilungschance nicht ergriffen, die Wandlung nicht gewollt oder vollzogen werden kann, die archetypischen Kräfte in der therapeutischen Beziehung nicht ‘humanisiert’ werden können, wirken sie zerstörerisch.”⁴ (Wirtz, 2006, p. 18) Persons who have gone through significant posttraumatic growth can develop wisdom. They have an awareness of paradox as part of life, they can tolerate paradox as part of our existential condition, and they do not primarily listen to their heads only, but simultaneously to their heads and hearts. (Wirtz, 2003, 2006)

However, not all posttraumatic growth reported by survivors might be authentic growth. Authors suggest that these reports might be 1. self-enhancing and self-protecting illusions, 2. active coping-efforts, or 3. they might reflect a real outcome or adaptation. The level of symptom-reduction may be an indication whether the posttraumatic growth is real

⁴ Translation: “Traumatic experiences can be a chance to contact the existential level as a gate to transcendence; but if the chance for healing cannot be used, if the transformation is not wanted or cannot be carried out, if the archetypal forces cannot be ‘humanized’ in the therapeutic relationship, then they have a destructive effect.”

or an illusion (Maercker & Zoellner, 2004; Nolen-Hoeksema & Davis, 2004; Stanton & Low, 2004). These authors also stress that even if it is an illusion, it might play an important role for coping with the stressors.

Concerning trauma therapy, Tedeschi and Calhoun (2004b) recommend that clinicians must feel comfortable and be willing to help their patients process their cognitive engagements with existential or spiritual matters and generally respect and work within the existential framework that patients have developed or are trying to rebuild in the aftermath of a trauma. Furthermore, although individual patients may need additional specific interventions designed to alleviate crisis-related psychological symptoms, listening – without necessarily trying to solve – tends to allow patients to process trauma into growth. (Tedeschi & Calhoun, 2004b, p. 2)

On the other hand they warn that focusing on growth after trauma should not come at the expense of empathy for the pain and suffering of the survivors, and that trauma is not necessary for growth (Tedeschi & Calhoun, 2004b).

The following parts of the literature review will describe specifically GIM and its adaptations, and PITT in the treatment of persons with Complex PTSD. These interventions are specific to this study. Other interventions are not explained here, as it would be beyond the scope of this study.

2.3 GIM and its Adaptations

In this part, GIM and its adaptations will first be described generally with special emphasis on the role of music, the role of imagery, and the role of the therapeutic relationship. Then the literature specifically on GIM and its adaptations in trauma therapy will be reviewed. There is a big amount of literature looking at music therapy in general in the treatment of trauma survivors. However, to review all of this literature would go beyond the scope of this thesis.

2.3.1 Description of the Bonny Method of Guided Imagery and Music (GIM)

The Association of Music and Imagery (AMI) officially defines the Bonny Method of Guided Imagery and Music (GIM) as a

music-centered exploration of consciousness. It offers persons the opportunity to integrate mental, emotional, physical, and spiritual aspects of well-being, as well as awaken to a greater transcendent identity. It is practiced primarily in psychotherapy and counseling settings. Specially sequenced classical music programs are used to stimulate and sustain a dynamic unfolding of inner experiences. Sessions in this one-to-one modality are conducted by facilitators with backgrounds in the helping professions who are formally trained in the Bonny Method. The Bonny Method has been used successfully with adults, adolescents, children, persons in recovery, psychiatric inpatients, terminally ill patients, and others. (AMI, 1990)

Bruscia (2002a) defines the individual GIM as

“1) an individual form 2) of exploring consciousness (e.g. in healing, psychotherapy, self-development, spiritual work), 3) which involves spontaneous imaging 4) in an expanded state of consciousness 5) to pre-designed (taped) programs of classical music, 6) while interacting with a guide 7) who uses nondirective, non-analytical, music-based interventions, 8) within a client-centered orientation, 9) all within a session that has the following components: preliminary conversation, relaxation/induction, guided music-imaging experience, return, and postlude discussion. These nine characteristics define the method, and all must be present to be considered the pure form of GIM, as originally developed by Bonny. Thus, if any of these characteristics are missing or significantly different from what has been described above, the method should not be regarded or labeled as GIM; rather it should be considered an adaptation of Bonny’s method ...,”

depending upon how many of the above defining features have been modified ...” (Bruscia, 2002a, p. 46)

According to Bonny (1978) each session contains a preliminary conversation and a post-session integration along with the session itself. In the preliminary conversation the focus is on the client's state of mind, feeling tone, and appearance. The therapist assesses the client's mood, energy level and level of vulnerability to arrive at a proper choice of music. In the post-session integration, therapist and client process the material. The therapist conducts an intake interview before the first session to get the client's life history.

These definitions correspond and/or supplement each other in most aspects. However, Bruscia holds that interventions have to be music-based which is not explicitly stated by the other authors. In my experience, music-based interventions are used along with other kinds of interventions. In a GIM session, the therapist might use many music-based interventions or none at all. I would not use the presence of music-based intervention as a defining factor of GIM. Bruscia, other than the other authors, also states that GIM is conducted within a client-centered orientation. However, Bruscia (2002b) himself describes GIM within a psychodynamic orientation. While Bonny originally developed GIM within a client-centered orientation, she already included other approaches as well, such as Jungian orientation, psychodynamic orientation, Gestalt theory, transpersonal psychology, etc. (Belland, 1994; Bruscia & Grocke, 2002).

Bonny (1994) states that

clients who are suitable for GIM therapy are those who (a) are capable of symbolic thinking; (b) can differentiate between symbolic thinking and reality; (c) are able and willing to report their experience to the therapist; and (d) can achieve growth as a result of the GIM therapy. Patients with psychosis are not suited for the treatment. The GIM process will reinforce psychotic thinking and may push them further into psychosis. (Bonny, 1994, p. 74)

2.3.2 Adaptations of GIM

Adaptations for of GIM for individual therapy are listed by Bruscia (2002a) as:

- “Contained spontaneous imaging
- Re-imaging (unguided and guided work ...)
- All directive approaches to guiding spontaneous imagery
- All uses of non-classical music in individual GIM sessions
- All shortened individual GIM sessions
- It does not include: projective listening, relaxation listening, directed music imaging.” (Bruscia, 2002a, p. 59)

He describes contained spontaneous imaging as follows: “In this approach to imaging the guide presents an image (e.g. a house), invites the traveler to explore one part of the image (the front door) for a few moments, then moves the traveler progressively along in the same image (into living room, dining room, etc.), so that the traveler images freely within a contained matrix, as presented throughout the imagery experience by the guide.” (Bruscia 2002a, p. 50) Re-imaging is described by Bruscia (2002a) as follows:

“In re-imaging, one person has a short [GIM] session focused on exploring a previous imagery experience of another person. The technique is used in individual, couple, and group settings, for clinical or supervisory purpose. The sessions are guided in individual and couple settings, but unguided in group settings. ... Re-imaging is a somewhat ‘contained’ form of imaging, in that the experience of the other person provides a container for exploring his or her imaginal world.” (Bruscia, 2002a, p. 51f)

Other adaptations of GIM not mentioned by Bruscia (2002a) are Music and Imagery (MI) and Music Breathing (MB). MI already exists for some years and it was defined in terms of content by Goldberg (1994, 2004) and Summer (1990), however, for a long time it was not clearly differentiated from GIM. MI works with a shorter music listening phase of 5-10 minutes – usually only one piece of music is used – and instead of going with the flow of imagery as in GIM, only one image is explored in detail. The relaxation and induction takes

place while the music is playing already. There is no conversation between therapist and patient during the music listening period, but the imagery can be expressed through painting, writing, or movement. (Geiger & Maack, 2010)

Music Breathing (MB) is an adaptation developed by Körlin (2008) for patients with Complex PTSD and dissociation. Its main purpose is for the patient to learn affect regulation through breathing and selected pieces of music. MB contains of four stages:

1. Grounded breathing without music
2. Grounded breathing adapted to the flow of the music
3. Modulated breathing adapted to the flow of the music
4. Imagery work similar to GIM but supported by the breath

2.3.3 The Role of Music in GIM and its Adaptations

GIM was developed from psychedelic (LSD) research and psychedelic psychotherapy. The role of music there was “1) ... helping the patient relinquish usual controls and enter more fully into his inner world of experiences; 2) ... facilitating the release of intense emotionality; 3) ... contributing toward a peak experience; 4) ... providing continuity in an experience of timelessness; 5) ... directing and structuring the experience.” (Bonny & Pahnke, 1972, p. 65f) When GIM was developed, the role of music expanded from this.

Music in GIM "is regarded as a process in the present, and as an immediately available language" (Toomy, 1997). It is neither important nor possible to choose music in a prescriptive way, trying to choose the right music for a certain disorder or mood state. The individual response to the music is highly subjective. Therefore it is important to "provide a good-enough musical space for each GIM client in each session; a musical space that contains enough, but not too much, nurturance and stimulation" (Summer, 1995). Grocke (2002a) describes the characteristics of the GIM-music as identified by Bonny: 1. Music is seen as a “catalytic agent that creates tension and release. ... Music that has an element of expectation and suspense may evoke more intense imagery responses. When the release

or climax is heard in the music, there may be a concomitant resolution in the imagery experience.” (Grocke, 2002a, p. 92) 2. Music acts like a container for the client’s imagery experience. 3. Music stimulates the flow and movement of the imagery experience. 4. GIM-music should have enough variability to stimulate the client’s imagery but not too much, otherwise it is perceived as disorganizing by the client. 5. The mood of the music is important for the imagery experience. According to Bush and Stokes (1999), music in the GIM process can have the following additional functions: 1. it can serve as a connector between mind, body, and soul, between inner and outer consciousness, and between thinking, feeling, sensing and intuition; 2. a catalyst - the musical language of rhythm, melody, timbre, etc. can encourage and enhance sensing, feelings, and imagery that arise from the unconscious; 3. it can be a carrier of archetypes and can speak to the collective unconscious; 4. it can serve as a projective screen - transference can be projected not only on the therapist but also on the music; 5. it can be a healer - the music itself can clear things out, can fill the client, can nurture or support the client.

Music as well as imagery and the therapists are used as projective screens for the client’s transference in GIM (Bruscia, 2002b; Maack, 2004b; Summer, 1998). Summer (1998) describes the advantages of a pure music transference:

1. “The client can have a more independent, separate status from the therapist from the beginning of the therapeutic process. This separation means that the client is more likely to attribute the gains he has made in therapy to himself or to his relationship with the music.” (Summer, 1998, p. 439)
2. In verbal psychotherapy the therapist must take a neutral stance to foster the client’s projection onto him. Music is more neutral than the therapist. It is ambiguous, not male or female, not stern or allowing, and it does not represent any specific object.
3. The therapist does not have to take all the transference onto himself. The music can serve as an (additional) container for the transference.

4. "Classical music can contain several experiences simultaneously. ... The key to the use of classical music in the transference is that its complex, multilevel nature allows the client a fuller transference experience by stimulating several facets of an experience simultaneously. ... This phenomenon is similar to the experience of transference in verbal group therapy." (Summer, 1998, p. 439f) The split between transference onto the therapist and transference onto the music, however, is somewhat illusory as the therapist chooses the music, and the music therefore is part of the therapist (Bruscia, 1995, 2002b; Maack, 2004b; Summer, 1998).

Bruscia (2002a) describes music as transformation and music *in* transformation. Both occur in GIM and its adaptations. In music *in* transformation, music is used for generating non-musical images and experiences. Music as transformation on the other hand, he describes as follows:

The imager steps into the structures and processes unfolding in the music from moment to moment, and begins to live with them, generating images and inner experiences that arise directly out of the music. And by living in these musical structures and processes as they continually transform themselves, the experiencer and the experience are similarly transformed. The entire phenomenon is intrinsically musical in nature, and similarly ineffable; and this seems to hold true, even if the imager tries to describe the experience verbally, using non-musical referents. (Bruscia, 2002a, p. 44)

The latter comes close to Josephson and Carpenter's (1994) theory:

Our model thus entails a Platonic picture of the mind, where much of the intelligence of the individual is the consequence of preexisting ideas in some mind-sphere. It follows that the study of music is at the same time the study of the quasi-genetic kinds aspects of this subtler realm of mind. Such studies may thus be able to inform us of aspects of mind not accessible to conventional studies that tend to focus on the more intellectual aspects of mind to the exclusion of its more intuitive ones. (Josephson & Carpenter, 1994, p. 3f)

The role of music in GIM and its adaptations can only be explained in part. To fully explain the role of music in GIM would mean to fully understand the nature of music itself.

Isenberg-Grzeda (1999) is the only author who describes the experience of music during a GIM-session from the client's perspective. In her text, I found five categories of experiencing music:

1. Supporting: Music as holding and enveloping the client. A blissful fusion with the music is experienced, while the therapist recedes into the background.
2. Challenging: Music as threatening or overwhelming. The client fights with the music, flees from it or succumbs to it.
3. Energizing: The client is filled with the energy of the music.
4. Physical: The music elicits a direct physical response in the client.
5. Structuring: The structure of the music gives structure to the inner chaos of the client.

2.3.4 The Role of Imagery in GIM and its Adaptations

Imagery in GIM and its adaptations may be created by the music directly stimulating the autonomic nervous system and through that, generating conscious and unconscious emotions. These emotions again may evoke images. These images may be further developed producing new imagery as long as the emotional connection with this flow of images remains. Once the emotional energy is spent, the affective influence of the music may return and a new circle of emotions and imagery flow starts. (Goldberg, 1992, 2002) Imagery in GIM and its adaptations can be visual, auditory, olfactory, gustatory, kinesthetic, emotional, sensory, intuitive, and noetic (Geiger, 2004).

Summer (1990) describes four different levels of imagery in GIM:

1. The aesthetic level which could contain a deeper experience of the music, altered perception of outer reality, experiencing of outer reality but within an emotional context, and surreal imagery (floating colors, abstract shapes, etc.)

2. The psychodynamic level which could contain (repressed) memories, conflicts, insights into aspects of one's life (can be in symbolic form), somatic experiencing, and body-memories.
3. The existential level which could contain images from the collective unconscious, myths and sacred stories, archetypes, the cycle of birth – death – rebirth, existential experiences, communication with spirits, and perinatal experiences.
4. The transpersonal level which may contain peak experiences, feelings of unity, sacredness, paradoxicality, ineffability, precognition, and out-of-body experiences.

Meadows (2002) describes how imagery is used and seen in GIM:

- Imagery experiences have layers of meaning. In GIM one image can have very different meanings, often even several meanings at the same time. All layers of meaning are equally valued.
- Imagery allows access to both conscious and unconscious material. Within the unconscious, there may be layers of levels of experience. Examples for that can be found in Bonny's Cut Log Model of Consciousness. This process of bringing unconscious material into consciousness with the help of imagery plays an important role in GIM.
- In GIM relaxation and concentration are used as techniques of moving in and out of the imagery experience.
- The role of the therapist in GIM is to support but not lead the client's imagery. The imagery process is guided by the client and by the music, which was chosen by the therapist.

2.3.5 The Role of the Therapist in GIM and its Adaptations

Bonny (1978) describes the functions of the therapist in GIM as

- Reflector and resonator, as sympathetic sounding board for affective reactions which may erupt in a session.

- Relaxer. Through use of the voice, through suggestion and, at time, through more directive use of imagery, [clients] can be helped to relax the tension which often accompanies the emergence of long-repressed emotion.
- Encourager, helper, and comforter.
- Listener and sharer – with more emphasis on listening. ... In a sense, he is a sharer as well, but the sharing revolves around, and interacts with, the ongoing flow of the [client's] experience, not the [therapist's] experience.
- Observer and recorder.

The therapists is

- “opening the [client] to new experiences;
- helping the [client] confront, assimilate, and deal with images, feelings, symbols and associations that arise;
- providing a contact with consensus reality by physical closeness, and quiet concentration;
- suggesting deepening techniques when the [client] is stuck in a nonproductive space;
- helping the [client], at the conclusion of the music session, review and integrate what has occurred.” (Bonny, 1978, p. 9)

Those functions of the therapist are consensus today (see also Geiger, 2004). On the other hand, the underlying dynamics and the meaning of the therapeutic relationship are understood in many different ways by different GIM-practitioners. Some completely ignore it (see for example Rinker, 1991), while others describe in detail the complex dynamics and systems of meaning in it (for example Bruscia, 1998). Isenberg-Grzeda (1998) ascribes this divergence to the role and organization of personal GIM therapy in the GIM-training. Other reasons may be the attitude of the trainers, supervisors, and/or personal therapists, and the mental-health training prior and in addition to GIM-training. The basis for understanding the dynamics and meaning of the therapeutic relationship are based on psychodynamic psychotherapy (Bruscia, 1995, 1998, 2002b; Isenberg-Grzeda, 1998; Wrangsjö, 1994),

object-relations theory (Summer, 1995, 1998), and Stern's theory of the infant's development (Geiger, 2007). Besides direct transference onto the therapist, in GIM there is also transference onto the music and the imagery which may be pure music or imagery transference or transference onto the therapist which is directed onto the music and/or the imagery (Bruscia, 1995, 1998, 2002b; Isenberg-Grzeda, 1998; Maack, 2004b; Summer, 1998; Wrangsjö, 1994). In addition, the therapist may project transference or countertransference onto the music or the client's imagery (Bruscia, 1998; Isenberg-Grzeda, 1998). Moser (1995) writes:

Es gibt Konstellationen kumulativer oder terroristischer negativer Übertragungen, bei denen der Analytiker nicht gleichzeitig haltende Figur, Garant des Arbeitsbündnisses und Übertragungsgestalt sein kann. Wird diese elementare Tatsache nicht berücksichtigt, so ist Leid für beide Partner des therapeutischen Dialogs die Folge, eine Einschränkung des bearbeitbaren Konfliktfeldes, die Auflösung des Widerstandsbegriffs, der Verlust der historischen Dimension und eine gemeinsame Regression auf ein kleinfamiliales Modell unter Ausblendung der Geschichte.⁵ (Moser, 1995, p. 92)

It is especially in these cases where split transference (onto the therapist, the music, and/or the imagery) can save the therapeutic alliance. In other cases, split transference allows for projecting a number of dynamics onto different objects simultaneously. On the other hand, split transference may obscure the transference and countertransference dynamics, so that it may become difficult for the therapist to follow what is going on in the therapeutic relationship. (Isenberg-Grzeda, 1998)

Geiger (2007) compares the role of the GIM-therapist during the music-listening phase with the role of the caregiver of an infant in Stern's developmental psychology (Stern, 2000). Geiger sees the role of the therapist during the music listening phase as very

⁵ Translation: "There are constellations of cumulative or terrorist negative transference during which the analyst cannot be container, guarantor of the working alliance, and projective screen for transference at the same time. If this basic fact is disregarded, the consequences are suffering for both partners of the therapeutic dialogue, limiting the treatable realm of conflict, dissolving of the concept of resistance, loss of the historical dimension, and a shared regression to the nuclear-family-model while disregarding history ..."

different from the pre- or post-session or from verbal psychotherapy. The interaction between therapist and client is more concrete and experience-based. Talking about the past or the future, relating the imagery to the client's life, or interpreting the material is done in the pre- and post-session, but not during the music-listening phase. Geiger (2007) highlights the following aspects of the role of the GIM-therapist which are similar to Stern's (2000) theory:

1. The therapist helps the client with cross-modal capacities. All sensory aspects of an image are linked together to describe the whole.
2. The therapist helps the client to modulate affect and work with vitality affects. This is not only done through verbal interventions (for example helping the client to go deeper into difficult affect vs. helping her to relax) but also through the choice of music. Similar to the infant's caregiver, the therapist runs the risk of over or under stimulation of the client.
3. The client and therapist together regulate interest and engagement in the imagery process. This is lead by selective attunement of both therapist and client.
4. Affect attunement is achieved by the selection of the music, the tone of voice of the therapist, and verbal interventions.
5. The therapist fosters verbal and narrative relatedness by encouraging the client to find words for her imagery-affective experience.

As most of the clients with Complex PTSD lack these early relational capacities as well as capacities for adequate affect regulation, GIM and its adaptations might be very helpful for their development according to this theory.

Other aspects here are transference, countertransference and the meaning of the therapeutic relationship with special regard to transpersonal experiences. The only finding here is from a study by Abrams (2002). He found that in transpersonal GIM experiences, there was more independence from the therapist then in non-transpersonal GIM experiences, as the imagery itself offered guiding support. More analyses of these in GIM are still to be done.

2.3.6 Pivotal Moments in GIM

“A pivotal experience in GIM occurs when embodied, distressful imagery or feelings are confronted and resolved, and this resolution brings about radical change in the person’s life.” (Grocke, 1999a, p. 220) Pivotal moments in GIM were researched by Grocke (1999a, 1999b, 2002b). She lists the following characteristics of pivotal moments in GIM:

- “Pivotal moments are recalled in vivid detail.
- The image lasts and ‘stands the test of time’.
- Pivotal moments may be unpleasant or uncomfortable.
- Pivotal moments may involve an embodied experience.
- The experience of pivotal moments is a lived experience. It has its own life and/or is experienced fully by the client.
- Pivotal sessions have a significant effect on the person’s life.
- Images are ‘building up’ toward the pivotal moment.
- Recurring images may be pivotal.
- Music is an important aspect of the pivotal moment.” (Grocke, 1999b, p. 301ff)

Grocke (1999a) differentiates pivotal moments in which clients struggle with difficult imagery and then resolve it, from peak experiences during which clients experience a state of bliss. Through choice of music and interventions, therapists may facilitate the pivotal moment. However, during the exact time of the pivotal moment, therapists often stayed silent and just allowed the clients to be with their imagery. The music used during pivotal moments was calm, slow, and had predictable harmonies, melodies, and a regular rhythm and pulse. (Grocke, 1999a, 2002b)

2.3.7 Practice of GIM and its Adaptations with Traumatized Clients

Traditional GIM with its very open focus during the music listening period often is too threatening for severely traumatized patients with low or medium ego-strength. Therefore GIM can be used in a more structured way (Blake & Bishop, 1994; Goldberg, 2002; Maack, 2004a; Pickett, 1992 & 1995; Pickett & Sonnen, 1993; Körlin, 2002). If we take Kluft, Bloom and Kinzie's (2000) descriptions of trauma patients into consideration (see 2.2.2), patients with little comorbidity and good ego-strength can benefit from traditional GIM. For patients with comorbidity, little ego-strength, and severe and prolonged symptoms of PTSD, traditional GIM is possible but often will need more structure, such as a shorter music listening period, music that is emotionally supportive⁶, a clear focus, and more directive interventions from the therapist. For patients with very severe and/or chronic PTSD-symptoms, very low ego-strength and/or severe comorbidity, only very structured adaptations of GIM are possible with focus on resources, talents and coping as described by Goldberg (1994). (Maack 2004a, 2006) Summer (2001) describes the different levels of therapy with music and imagery and the roles of music, imagery, and the therapist in the different methods:

⁶ Emotionally supportive music can be very different for different patients. Some patients find very gentle and simple music supportive as for example Pärt's "Spiegel im Spiegel". Other patients, however, do not trust gentle music, but find very hard and/or fragmented music supportive, for example Lens' "Flamma Flamma".

Table 2.3: Levels of Therapy with Music and Imagery

Method (level of therapy) Elements	GIM (reconstructive)	Music and Im- agery Therapy (re-educative)	Music and Imagery Therapy (supportive)
Music	Client's relationship with music is prime mover of therapy.	Holds client in current state or topic to work with an image.	Provides a common aesthetic experience – feeling of unity.
Imagery	Client's relationship is expressed through imagery. Internal experiences are divided into manageable pieces.	Provides constant internal objects with which to work and to relate to the therapist.	Connects client with internal world. Provides a positive internal experience.
Therapist	Supports client's responsiveness to the music by working with his/her imagery experience.	Primary mover of the therapy; helps divide the internal world into manageable pieces.	Primary mover of the therapy; helps client connect with positive resources.

The table shows that the role of the music becomes more prominent in less structured approaches while the role of the therapist becomes more of a witness. In the more structured and supportive approaches the therapist is the prime mover of therapy while the music is just an aesthetic presence. This does not mean that transference and countertransference become less important in GIM if compared to re-educative or supportive music and imagery therapy. My opinion is that the transference and countertransference becomes more complex and deeper the deeper and more open the therapeutic experience is. The role of imagery becomes more complex the less structured the approach is.

GIM can help traumatized patients with “transformation of traumatic imagery into symbolic imagery, establishment of cognitive memory and understanding, and integrating the resulting discursive symbols with analogic symbol and affect.” (Körlin, 2002, p. 406) Other outcomes described in the literature are: finding and trying out resources (Körlin, 2002; Pickett, 1992; Pickett & Sonnen, 1993), increased self-esteem (Blake, 1994; Körlin, 2002; Pickett, 1992), getting in touch with and working through feelings and emotions

(Blake, 1994; Tasney, 1993), greater sense of hope, increased relaxation, decreased hypervigilance (Blake & Bishop, 1994), reduction of intrusive thoughts (Blake & Bishop, 1994; Körlin, 2002), anger control, decreased addiction (Pickett, 1995), and decreased numbing (Körlin, 2002). Körlin, Nybäck and Goldberg (2000) explored the outcome of a creative group unit for psychiatric patients with different diagnoses. The therapeutic program consisted of a body awareness group, Group GIM, art therapy, occupational therapy and verbal group therapy. Outcome measurements were the Hopkins Symptom Check List-90 Revised (SCL-90-R), the Inventory of Interpersonal Problems (IIP) and the Sense of Coherence (SOC) scale. It was found that “traumatized patients did better than non-traumatized ... Patients with an eating disorder have significantly better treatment results in the SCL-90-R than patients without, and strong tendencies in the same direction are in the IIP and SOC. Patients with abuse or suicidality tend to do better than those without these condition in total scores and most subscales.” (Körlin, Nybäck & Goldberg, 2000, p. 338) The authors hypothesize that creative arts therapies, including GIM, are especially useful for patients with dissociative conditions.

2.4 Psychodynamic Imaginative Trauma Therapy (PITT)

This section covers a general description of PITT and the role of imagery and of the therapist within this method. As this is a rather new method – it was only conceptualized as a method of intervention in 2004 (Reddemann, 2004) – there is obviously only a limited amount of literature on PITT which will be described in this section.

2.4.1 Description of PITT

PITT was developed by Luise Reddemann from clinical work with patients with Complex PTSD and trauma-related Borderline Personality Disorder. Luise Reddemann is a psychiatrist, neurologist and psychoanalyst. She is also trained in family therapy, body-oriented psychotherapies and imagery work in therapy. From 1985 – 2003 she was the

head of a hospital for psychotherapy and psychosomatic medicine. She is currently teaching psychotraumatology, belongs to the scientific committees of several conferences and published several books and articles. (Reddemann, 2004)

PITT was only recently conceptualized (Reddemann, 2003; 2004). It is based on analytical objects-relations theory, ego-psychology, the use of perception of transference and countertransference, and the concept of ego-states as described by Watkins and Watkins (1997). It uses a 3-phase model of stabilization, trauma confrontation, and integration as described by Herman (1998), working also in a process-oriented way. Similar to GIM, it stresses self-regulation and self-healing; both methods are, among others, working with images of the body (Reddemann, 2003; Summer, 1990). In the stabilization-phase, imagery is used for developing nurturing and protecting resources, which can help the patient to control her feelings rather than constantly being overwhelmed by them. The patient also learns to explore different parts of herself, who then can communicate with each other and with the therapist. During the phase of trauma confrontation, imagery is used to reconstruct the traumatic events on all levels (behavior, affect, sensation, cognition) using Braun's (1988) BASK model. During that phase techniques are used that help the patient to distance herself from the traumatic event (to prevent re-traumatization) while at the same time describing it. Music is not used in this method.

Reddemann (2003) states, that PITT helps patients to decrease acting-out behavior. After treatment with PITT, patients report to feel empowered. In a study conducted by Lampe et al. (2008) it could be shown, that abilities for self-soothing and calming oneself significantly improved and symptoms of depression measured with the Becks Depression Inventory were significantly reduced in severely traumatized patients treated with PITT in an in-patient setting compared to a control-group. It also showed that symptoms in these patients decreased proportionally to the ability to calming oneself. One problem in this study is the control-group which was a group of patients waiting to be admitted to the hospital where the study took place. During their waiting-period they were treated with psychiatric or psychotherapeutic treatment (but no trauma-therapy) in an

outpatient-setting. What was actually measured here was trauma-therapy in an inpatient-setting vs. normal psychotherapy (no trauma-therapy) in an outpatient-setting.

Sachsse et al. (2006) studied the in-patient treatment with PITT and Eye Movement Desensitization and Reprocessing (EMDR) for women with complex PTSD and concomitant borderline personality disorder on a specialized trauma-ward for women only. They took measures at the beginning of treatment, at the end of treatment (2 – 4 months later), and again after a 1-year follow-up period. Results show significant improvement 1. in the use of primitive defense mechanisms in the Borderline Personality Inventory, 2. in the total scores of the Dissociative Experiences Scale, especially in the area of absorption, and 3. in avoidance measured by the Impact of Event Scale from pre- to post-treatment. The results stayed stable over the 1-year follow-up period. The average number of in-patient days per year for these women dropped from an average of 87 days before the treatment to an average of 9 days after the treatment. Self-mutilating behavior dropped from an average of 7 times per month before treatment to an average of once per month after treatment. A problem in this study is the missing control-group. Up to now, there are no studies done with PITT in out-patient treatment.

2.4.2 The Role of Imagery in PITT

In individual PITT imagery is used in the therapeutic dialogue. There is no explicit induction into an altered or relaxed state of consciousness. This means that ASC may or may not occur in PITT. While the patient is always creating her own imagery, the therapist helps the patient to do so by asking questions like “How does (for example) a safe place look like?”, “What does it need to be safe?”, “Are you alone, or would you like to have helping beings there?”, etc. (Reddemann, 2004, p. 101). Reddemann (2004) stresses, that the therapist should lead as little as possible, so that the patient can find her own ways of creating imagery. Therapists should accompany, inform, and encourage the patient rather than instruct her of what exactly to do or to see. The therapist’s way of asking questions in a focused but still open way comes close to music and imagery as described by Summer

(2001). The language in PITT, however, is rather like in a regular psychotherapeutic dialogue than like the language used during ASC. As the imagery work is blended into the therapeutic dialogue, there is no set session structure as in GIM. These comments are equally relevant for the next section on the role of the therapist.

Similar to GIM, imagery in PITT can be visual, auditory, kinesthetic, etc. There is no preferred mode of imaging, but the way imagery is formed is up to every individual patient. Reddemann (2004, p. 61) writes: “Das innere Erleben kann durch auditives oder kinästhetisches Wahrnehmen genauso intensive sein wie durch visuelles, und innere Bilder können dadurch verstärkt werden.”⁷

Reddemann (2004, 2006) sees the value of working with imagery in PITT as trying out things before doing them in real life, and as creating new ways of being or new possibilities in a safe and creative way. Imagery can form and influence the brain as much as real experiences can – a concept that is reconfirmed by neurobiology (Hüther, 2004a; Reddemann, 2004, 2006). Traumatized patients can learn to better care for themselves, to cope with overwhelming emotions and feelings, and to reconstruct their inner systems (for example finding a good place for the inner child instead of leaving her in the traumatic experience and in pain) through the use of imagery.

Reddemann (2001) also mentions the advantage of splitting the transference. When working with imagery, transference can be projected onto the therapist and onto the imagery, which is especially helpful with the sometimes very devastating transferences experienced in the work with traumatized patients. Many of these concepts we find in GIM and its adaptations as well.

2.4.3 The Role of the Therapist in PITT

Reddemann (2006) writes:

⁷ Translation: “Inner experiences can be as vivid if they kinesthetic or auditory as if they were visual, and inner pictures can become more vivid if kinesthetic or auditory perceptions are integrated into visual ones.”

Psychodynamische Therapien haben schon immer mehr auf den Beziehungsaspekt gesetzt, als dies einige heute stark verbreitete Traumabearbeitungstechniken tun. So kann gerade bei komplexen Traumafolgestörungen ein an modernen psychodynamischen Konzepten orientiertes Verstehen und Intervenieren sowohl die Patientin wie ihre Therapeutin besser schützen als die auf schiere Traumabearbeitung ausgerichtete Technik. Dazu kommt ein Verständnis von Beziehungsaspekten i.S. von mehr oder weniger bewussten Beziehungsreinszenierungen, die unter dem Blickwinkel von Übertragung und Gegenübertragung eingeordnet und verstanden und dadurch auch gehandhabt werden können.⁸ (Reddemann, 2006, p. 11)

Within the psychodynamic framework, the concept of transference and countertransference in trauma-therapy is embraced as described in section 2.2.2. Therapists should be aware that often countertransference precedes transference when working with traumatized patients. Reddemann (2004) also cautions against encouraging a transference-neurosis through a neutral attitude of the therapist. Neurotic patients, for whom encouraging a transference-neurosis would be indicated, often are overly socialized. Patients with PTSD and especially Complex PTSD often are socialized too little, so that a too neutral attitude of the therapist might foster unconscious self-accusations or intrusive trauma-memories which may be re-traumatizing (Fischer & Riedesser, 1998; Reddemann, 2004).

In PITT the therapist's attitude towards the patient should be friendly, interested, and responsive. Transparency in therapy is important for helping the patient to feel safe. For traumatized patients, who experienced existentially threatening situations in their lives, this is seen as especially important. The therapeutic relationship in PITT should be a working-alliance between therapist and patient (Reddemann, 2004).

⁸ Translation: "Psychodynamic therapies always used to put more emphasis on the therapeutic relationship than some of today's widely used techniques for working with trauma. In that way an understanding and interventions based on psychodynamic concepts can better protect the patient and her therapist than a technique merely geared towards working through the trauma, especially when working with Complex PTSD. In addition there is an understanding of relationship aspects in the sense of more or less consciously reenacting relationships, which are understood and therefore handled as transference and countertransference."

Wenn in der Therapie Probleme, welcher Art auch immer, auftreten, sollte sich die Therapeutin zunächst immer die Frage stellen, ob die therapeutische Beziehung tragfähig ist. Dazu gehörten vor allem Takt, Zugewandtheit, die Bereitschaft, neue Erfahrungen zu ermöglichen, und die Bereitschaft, eigene Fehler einzugestehen und sich, wenn nötig, dafür auch zu entschuldigen.⁹ (Reddemann, 2004, p. 48)

2.5 Conclusion

There are no outcome-studies of GIM and its adaptations or PITT in the outpatient-treatment of persons with Complex PTSD, yet, nor has there been any studies looking at the role of music, imagery and the therapeutic relationship within these therapies from the point of view of the traumatized clients. However, the current literature supports that both methods might be helpful in outpatient treatment of Complex PTSD. Based on the literature reviewed in this chapter and on my research interests outlined in Chapter 1, the following research questions were developed:

5. Is GIM, PITT, or both of these methods indicated for severely traumatized adult patients?
6. When would GIM and when would PITT be indicated?
7. What are different roles of music in imagery-based trauma therapy?
 - a) What could music be particularly helpful with?
 - b) Are there limitations in the use of music?
8. What are characteristics of the treatment of patients with Complex PTSD?

To study these phenomena I decided to use a mixed design of quantitative outcome studies and heuristic research. Research questions 1 and 2 were answered through the empirical outcome study. Research questions 3, 4, and 5 were answered by the qualitative interview study.

⁹ Translation: "If whatever kind of problems arise in therapy, first the therapist should ask herself if the therapeutic relationship is sound. This needs delicacy, interest, being open for making new experiences possible, and the openness for admitting one's own mistakes and, if necessary, apologizing for them."

Chapter 3: METHODS

3.1 General Description of the Study

The study is a mixed-methods-design divided into a quantitative and a qualitative part with the aim of answering the research questions presented in the introduction. The quantitative part is a comparative outcome-study of two imagery-based methods of trauma-therapy: PITT and GIM and its adaptations. The study is based on the premise that both methods are indicated as treatment for women with Complex PTSD. However, it was hoped that different results in the different questionnaires used or in its subscales may point to areas in which music may be more or less helpful in their therapy. At this point it should be mentioned however, that research shows that psychotherapy in general is helpful for about 75% of all patients (independent of diagnosis), no matter what kind of method is used, and only about 8% of the outcome is due to specific methods (see for example Wampold, 2001). The researcher holds that the most important aspect of trauma therapy is the therapeutic relationship, but it is also shown that certain therapy methods are helpful for traumatized patients while others are harmful (see for example Luxenburg et al., 2001b).

In the qualitative part, heuristic research was used to find out about the meaning of music, imagery and the therapeutic relationship for the research participants. The whole study took place in a naturalistic setting and focused on the clients' perspective of the phenomena.

As research participants came from different countries and were also treated in different countries, cultural issues may play some role in the discussion of the data. Those cultural issues, however, can only be discussed later in the process when it is known from which countries the research participants were.

3.1.1 Operational Definitions

GIM in this study is defined as an individual form of exploring consciousness in psychotherapy, which involves spontaneous imaging in an expanded state of consciousness while experiencing classical music and interacting with a therapist who uses nondirective, non-analytical interventions within a session that has the following components:

- preliminary conversation
- relaxation/induction
- music-imaging experience
- return
- postlude discussion.

Adaptations of GIM as defined under 3.1.2. can be used in this study as well.

PITT is defined as a psychodynamic method of trauma therapy using imagery and is conducted as described by Reddemann (2004).

In this study a person is seen as suffering from Complex PTSD if all subscales of the SIDES-SR (description see below) except # IV (“alteration in perception of perpetrator”) are assessed as applicable. If a client does not qualify for the diagnosis of Complex PTSD as assessed by the SIDES-SR at the beginning of treatment, this client will not be included into the study.

3.1.2 The Use of GIM and its Adaptations in this Study

In this study, GIM and its adaptations were used by GIM-therapists. As discussed under 2.3.7., traditional GIM often is too open for clients with not enough ego-strength. In that case, adaptations could be a good alternative. GIM is already defined under 3.1.2. Possible adaptations that can be used instead of GIM are:

- Contained spontaneous imaging
- All directive approaches to guiding spontaneous imagery
- All uses of non-classical music in individual GIM sessions
- All shortened individual GIM sessions (see also Bruscia, 2002a)

Contained spontaneous imaging is defined as follows:

In this approach to imaging, the guide presents an image ..., invites the traveler to explore one part of the image ... for a few moments, then moves the traveler progressively along in the same image ..., so that the traveler images freely within a contained matrix, as presented throughout the imagery experience by the guide. (Bruscia, 2002a, p. 50)

The following receptive music therapy methods can be used in the study but are not counted as adaptations of GIM:

- Projective listening
- Relaxation listening
- Directed music imaging

In projective listening,

the therapist presents music to clients who are in an ... ordinary state of consciousness, and then asks the client to react to it imaginatively. ... GIM is different from projective listening in that, in GIM, the therapist encourages the client to enter an expanded state of consciousness, whereas in projective listening, the therapist works to maintain ordinary levels of consciousness

In relaxation listening, the music therapists narrates a relaxation induction ..., using supportive music in the background. ... The client is encouraged to follow the image presented by the therapist rather than to allow additional personal images to arise. ... In relaxation listening, the image and music are used to induce and maintain an extended period of relaxation. (Bruscia, 2002a, p. 48f)

In directed music imaging the traveler is taken “step-by-step through an imagery experience that activates, reproduces, or rehearses a desired process or outcome ... The guide directs the traveler in a very detailed way, specifying all aspects of the imagery experience from beginning to end ...” (Bruscia, 2002a, p. 50f)

Further aspects of the therapy for the GIM-group are explained under 3.2.2.

3.1.3 Naturalistic Setting

The research took place in a naturalistic clinical setting: Each client chose her therapist and the method with which she wanted to work. The therapists were free to adapt their interventions to the needs of their clients. However, they were asked to work according to the current standards of trauma-therapy for patients with Complex PTSD, and PITT-therapists were instructed not to use music. When using GIM or its adaptations or PITT, therapists were also expected to stay within the general protocols of the methods as defined in the literature mentioned in sections 2.3. and 2.4. Therapists were free to choose the frequency and length of sessions, the way of using GIM and its adaptations or PITT, and the use of additional techniques (such as EMDR).

Therapists were given relative freedom within the therapy due to the complexity of the disorder. This complexity often asks for creativity and searching for new possibilities both from the therapist and from the client. An overly fixed therapy protocol would not allow for this creativity. This would even bring up the question if it would be ethical to withhold something from the client that might be necessary for healing.

Randomization would not be possible in private-practice settings and was therefore not used. But the client-groups were matched as described in 3.2.1.

3.1.4 General Aspects of Research in the Field of Psychotrauma

Fischer and Riedesser (1999) suggest a mixed-methods-design especially when doing research in the field of psychotrauma. A rather general statement on a questionnaire may mean different things to different persons. For example a statement like “Even small problems may irritate me very much” gives many options for interpretation: What is a small problem? One survivor may consider the fact that butter for the cake is missing as a small problem, another survivor may consider the fact that she is raped daily by her husband as a small problem. And what does “irritate me very much” mean? Giving somebody an angry look, or throwing the cake-tin and its contents at the children? To

clarify this, it is suggested to combine standardized questionnaires with qualitative research, for example in the form of interviews.

Fischer and Riedesser (1999) also mention social-psychological defense-processes when researching trauma which may lead to false interpretation of data or influence the setup of the research-design. They list the following defense-processes:

1. Repressed or not sufficiently processed traumatic experiences of the researcher may hinder or distort the understanding of other persons' traumatic experiences.
2. A traumatized researcher might favor her own coping strategies over other coping strategies. The researcher might not be willing to consider the whole spectrum of different traumatizations with all its possible effects and coping strategies, but rather tends to generalize her own experiences and its effects. Personal traumatizations should be worked through enough, so that the researcher can be open for the experiences of other people.
3. The researcher might blame the victim for what happened to him. When looking at a traumatic event in retrospect, one might get the illusion that it could have been prevented (if the victim had taken a different road, not traveled to a "dangerous" country, not have invited her into his home, etc.). In retrospect one knows that an event was possible, so it was also probable, so it was predictable, and so it is controllable – this could be the fallacy when looking at something in retrospection.
4. When dealing with traumatization within the family, an attitude of unconditionally "saving the parents" or "blaming the parents" can sometimes be observed. Both attitudes can severely distort research findings if the respective attitude stays unreflected.

While the last two points are relevant especially when researching trauma histories, the first two points are relevant also for researching treatment methods and outcome. For this study it means that personal attitudes towards trauma, PITT therapy and GIM therapy as trauma-therapy have to be clearly stated. This is done below in part 3.3.2.

3.1.5 Research from the Clients' Perspective

In heuristic research one

seeks to discover the nature and meaning of the phenomenon itself and to illuminate it from direct first-person accounts of individuals who have directly encountered the phenomenon in experience. ... The focus in a heuristic quest is on recreation of the lived experience; full and complete depictions of the experience from the frame of reference of the experiencing person. (Moustakas, 1990, p. 38f)

Other than in qualitative third-person research where the researcher "may use self-inquiry to monitor the integrity of the study" (Bruscia, 2005, p. 379), in heuristic or first-person research "researchers study themselves to provide the primary source of data" (Bruscia, 2005, p. 379). While in third-person research a phenomenon is investigated from the outside, in heuristic research the phenomenon is reflected on and explained from the inside of one or more persons in whom this phenomenon is living. I do not see it as better or worse, but as adding another dimension or looking at a phenomenon from another angle with less distance but maybe more depth.

Different sources such as clients, therapists, independent judges and the client's environment usually do not agree on the client's therapy outcome (Bond et al., 1979, Fiske 1975, Greenberg & Pinsof 1986, Gurman & Kinskern 1981). The therapist is the best source for information about psychodynamics and personality structure; while objective observers best describe simple behavior counts, performance on clinically relevant objective criteria (for example self-mutilating behavior), and for perceived interaction patterns. The client is seen as the best source of information about outcome in the areas of individually or interactionally focused behavior, interpersonal change, the self in relation to others (Gurman & Kinskern, 1981), happiness, and gratification of needs (Strupp & Hadley, 1977). The client's judgment, however, may be biased by factors as

not wanting to displease the therapist, suggestion, and the need to rationalize her investment of time and money (Garfield, Prager & Bergin, 1971).

3.2 The Quantitative Part of the Study

3.2.1 Research Participants

Research participants were female adult patients suffering from Complex PTSD with or without co-morbidity due to prolonged interpersonal traumatization ($N = 136$). Patients with psychosis, mental disorders due to a general medical condition, cognitive disorders, or patients who at the beginning of treatment were actively abusing substances were not included in the study. Another exclusion-criterion was a pending lawsuit against any of the perpetrators in the beginning of treatment.

The research participants belonged to one of the following groups:

1. Patients treated with individual outpatient psychotherapy using GIM or its adaptations;
2. Patients treated with individual outpatient psychotherapy using PITT;
3. Control group: Patients on a waiting list for individual outpatient psychotherapy;
4. Separate but matched follow-up group: Patients who had been in individual outpatient psychotherapy using GIM or its adaptations, but finished therapy at least one year before filling in the questionnaires. During their therapy, they had at least 16 therapy-hours of GIM or its adaptations.

At an $\alpha = .05$ and within an assumed $R^2 = 0.36$ ($r = 0.6$), the required sample size for 80% power was aimed to be found out. The result showed that 34 research participants per condition were needed. As there were three measurement-points the actual power is higher.

The participating women were between 18 and 64 years old at the beginning of their treatment if they belonged to groups 1-3, or at the time they filled out the questionnaire if they belonged to group 4, with a mean age of 40 and a median age of 41. Of all

participants 78 are German, 38 are US American, six are Swedish, five are Swiss, four are Turkish, three are Spanish, one is Croatian, and one is Danish. Sixty women were married or living with a partner at the beginning of their treatment, and 74 were not married and / or not living with a partner. Thirty-eight of them have less than a high school education, 39 have a high school degree or international equivalent, and 59 have a university degree. Five of the women were retired, 11 were unemployed, 18 were still in training for a job, 21 were self-employed, 25 stayed at home with their children, and 56 were employed. Participants had between zero and five children with a median of one child. Between zero and three of the children were still living at home with a median of zero children at home. All but two of the participants' fathers were at an age between 19 and 39 when the research participants were born. Two fathers were 40-59 when the participants were born. Two of their mothers were older than 39, 26 mothers were younger than 19, and 108 mothers were between 19 and 39 years old when the participants were born. Of the participants' fathers 106 were still alive when they started treatment, 23 of the fathers had died when the participants were older than 18 years old, and five when the participants were younger than 18 years old. Of the participants mothers 119 were still alive at the beginning of therapy, twelve mothers had died when the participant was older than 18 years, and four mothers had died when the participant was younger than 18 years old. Thirteen of the participants' parents were never married, or divorced before the participant was born, 107 were married, and 16 were divorced after the participants' birth. The participating women had zero to seven siblings with a median of one sibling.

At the beginning of their treatment, 34 of the women had no comorbidity, 42 had one additional psychiatric diagnosis, 43 had two additional diagnoses, 16 of them had three additional diagnoses, and one had four additional diagnoses. The additional diagnoses reported were depression, borderline personality disorder, dependent personality disorder, eating disorders, narcissistic personality disorder, social phobia, sleep disorders, dissociative identity disorder, conversion disorder, elective mutism, vaginism, and burn-out.

The following table shows how many participants in each group were on medication, and how many participants per group needed hospitalization during their therapies:

Table 3.1: Medication and Hospitalization during Therapy or Waiting

	Number of participants on medication	Number of participants who needed hospitalization
Guided Imagery and Music Treatment Group	0	1
Psychodynamic Imaginative Trauma Therapy	14	9
Control	10	7
Guided Imagery and Music Follow-up Group	3	4

($n = 34$ per group)

The table shows that participants in the two GIM groups needed less medication and fewer hospitalizations during their therapies than participants from the other two groups. For the GIM follow-up group, it should be taken into consideration that the therapy time for these participants was much longer than for the other groups.

In the last part of this section we look at attrition, participants dropping out of their therapy, participants finishing their therapy earlier than after 50 therapy hours, and potential participants who were excluded from the study in each of the four groups. From the GIM treatment group, one participant could not continue with her therapy after just a few therapy hours, because the participating therapist changed her work-place and therefore could not continue treating this participant. The pretest data from this participant was not taken into the study. Another participant from the GIM treatment group finished her therapy after 25 therapy hours. Her data from the mid-point was carried through to the end. There was no attrition, exclusion from the study, or other irregularities in the GIM follow-up group.

One of the participants from the PITT treatment group ended her therapy after 25 therapy hours. It is not clear whether she finished her therapy or she dropped out from therapy. Her data from the mid-point measures were carried through to the end. From the control group, four potential participants were not taken into the study because they were able to start therapy less than 9 months after filling out the pretest questionnaires.

3.2.2 Therapists and Therapy

For the recruitment of the two treatment-subgroups, the researcher contacted therapists who had finished formal training in GIM or PITT (for contact letters see Appendix A). For GIM the list of therapists invited for the European GIM Conference and the AMI Fellows Directory were used. In addition letters were forwarded by the Danish GIM Association, the New Zealand Imagery and Music Association (NZIMA) and the Music and Imagery Association of Australia (MIAA) to their members. GIM-therapists included in the study as clinicians had finished formal GIM training, had at least Bachelor's degrees in the clinical mental health field or an international equivalent, and had experience working with severely traumatized patients as primary psychotherapists.

PITT-therapists were invited to take part in the study by the training institute. The PITT-therapists included were trained both in supportive PITT as well as in trauma confrontation with PITT. PITT-therapists were licensed psychotherapists or counselors and held at least Bachelor's degrees in the clinical mental health field or an international equivalent.

The PITT-therapists were asked to conduct therapy according to Reddemann's (2004) manual. They did not use music in their treatment. The GIM-therapists were asked to conduct therapy as described above (see 3.1.2.). Both groups of therapists were asked to observe general standards of trauma-therapy. At least 16 of the 50 therapy-hours contained GIM or its adaptations, or PITT respectively. Therapists were asked to list other therapy-interventions used within their therapy with the respective client like for example Eye Movement Desensitization and Reprocessing (EMDR), etc. if applicable. Therapists

were also asked to list reason and length of any hospitalizations during the course of therapy, or if she started using drugs or alcohol.

The therapists asked patients to fill in questionnaires after the first 3 – 5 assessment-hours, after 25 therapy-hours, and after 50 therapy-hours. The therapists briefly explain the questionnaires to the research participants, answer questions if necessary, and encourage the research participants fill the questionnaires out completely without leaving questions unanswered. The clients gave the questionnaires back to their therapists in a closed and sealed envelope, so that the therapist was not able to read the answers. The therapists then sent the questionnaires back to the researcher. The researcher was not one of the therapists.

For the follow-up group, therapists contacted former clients and asked them if the therapist could give the client's address to the researcher. The researcher then sent questionnaires to the clients who filled them out and sent them back directly to the researcher.

Research participants sign informed consent forms (see Appendix B). The informed consent forms from the two therapy-groups and from the control group are kept by the therapists or hospital, so that the researcher will not be informed about names of those research participants. The informed consent forms of the follow-up group are kept by the researcher.

All of the women either found a therapist of the preferred gender or the gender of the therapist was not important for them. Of all participants 84 had perpetrator contact during their time of therapy or waiting, and 49 had not. Before they started with their therapist, participants had 0-8 initial interviews with other therapists with a mean of one initial interview with other therapists, and a median of none. For their therapy, participants had to wait 0-54 weeks for the beginning of their therapy with a mean of 10 weeks. The following table shows the waiting time per group:

Table 3.2: Waiting Time for Therapy per Group

	Waiting time in weeks			
	Minimum	Maximum	Mean	Median
Guided Imagery and Music Treatment Group	0	12	0.85	0
Psychodynamic Imaginative Trauma Therapy	0	54	22.03	8
Guided Imagery and Music Follow-up Group	1	26	8.28	4

(*n* = 34 per group)

Participants from the GIM follow-up group had between 26 and 300 therapy hours with their GIM-therapist with a mean of 165 therapy hours and a median of 160 therapy hours. The total length of the therapy here is noteworthy. In Germany it would be in the range of Analytical Psychotherapy. Long therapies appear to be normal for this clientele. After their GIM-therapies they had 0-1 other therapy with a mean and median of 0 therapies. The questionnaires for this study were filled out 15-120 months after termination of the GIM therapy with a mean of 48 months and a median of 35 months.

Next the therapists of the two GIM-groups and the PITT-group are described. Therapists for the GIM treatment group and for the GIM follow-up group were the same. As the therapists took part in the study for some years, all data on age and experience of the therapists refers to the time of the beginning of the treatment of the first research participant in the GIM or PITT treatment group.

Ten GIM therapists took part in the study, one male and nine female therapists. They were 40-63 years old with a mean age of 49. Two therapists are German, two are Swedish, five are US American, and one is Danish. None of them practices in a foreign country. Four of the therapists have university degrees in music therapy, three of them in psychology, and one each in psychiatry, social work, or counseling. All GIM therapists in the study have training in trauma therapy. In their offices, patients with Complex PTSD make 10-95 % of their patients with a mean of 74 %. The therapists have 7-26 years of experience with patients with Complex PTSD with a mean of 15 years. Besides GIM, all therapists are trained in at least one more therapy method, six are trained in two more

methods, three are trained in three more methods, and one is trained in four more methods. The psychotherapy methods these therapists are trained in are psychodynamic psychotherapy, cognitive behavioral therapy, client centered psychotherapy, group psychotherapy, pastoral counseling, Eye Movement Desensitization and Reprocessing (EMDR), somatic experiencing, and shamanic counseling. Four of the GIM therapists are also primary trainers for GIM.

Eight PITT therapists took part in the study, one male and seven female therapists. They were 48-55 years old with a mean age of 51.5. Six therapists are German, one is Swiss, and one is Italian. They all practice either in Germany or Switzerland. Four of the therapists have university degrees in psychiatry, two in psychology, and one in both psychiatry and psychology. All PITT therapists in the study have training in trauma therapy. In their offices, patients with Complex PTSD make 20-80 % of their patients with a mean of 54 %. The therapists have 8-18 years of experience with patients with complex PTSD with a mean of 11.5 years. Besides PITT, all therapists are trained in at least two more therapy method, two are trained in four more methods, one trained in five more methods, one is trained in six more methods, and one is trained in eight more methods. The psychotherapy methods these therapists are trained in are psychodynamic psychotherapy, cognitive behavioral therapy, client centered psychotherapy, Gestalt therapy, group psychotherapy, family therapy, play therapy, EMDR, hypnosis, Ego State Therapy, NLP, psycho-oncology, and addiction counseling.

In the GIM treatment group, 26 of the research participants had therapy once a week, six participants had therapy every other week, and two had blocks of GIM therapy (for example three sessions in three days, and then a break of a month before the next block of three sessions in three days). The length of one therapy session varied from 50 to 150 minutes per session with a mean of 101 minutes and a median of 120 minutes. In 18-40 of the 50 therapy hours GIM was used with a mean of 27 and a median of 24 hours. During the other therapy hours, mainly verbal therapy was used.

In the GIM follow-up group, 15 of the research participants had therapy once a week, seven participants had therapy twice a week, five participants had therapy every other week, and seven had blocks of GIM therapy. The length of one therapy session varied from 50 to 160 minutes per session with a mean of 103 minutes and a median of 120 minutes. Participants had between 18 and 198 therapy hours in which GIM was used with a mean of 104 and a median of 99 hours.

In the PITT treatment group, 22 of the research participants had therapy once a week, ten participants had therapy every other week, and one had irregular intervals between therapy sessions. The length of one therapy session varied from 50 to 65 minutes per session with a mean of 51 minutes and a median of 50 minutes. In 16-43 of the 50 therapy hours PITT was used with a mean of 31 and a median of 28 hours.

3.2.3 Quantitative Measurements

The following questionnaires were filled out by the clients after 3-4 therapy-hours, after 25 therapy-hours, and after 50 therapy-hours:

1. The Self-Report Inventory for Disorders of Extreme Stress (SIDES-SR) by van der Kolk (2002) (main outcome)
2. The Dissociative Experience Scale-Taxon (DES-T) by Waller, Putnam and Carlson (1996)
3. The Somatization Dissociation Questionnaire (SDQ-5) by Nijenhuis et al. (1996)
4. The Inventory of Interpersonal Problems for Personality Disorders (IIP-PD25) by Kim and Pilkonis (1999)
5. The short version of the Sense of Coherence Scale (SOC) by Antonovsky (1987)

The SIDES-SR is a 45-item self-report measure of baseline severity of Complex PTSD; baseline severity of each of the six symptom clusters of 1) alterations in regulation of affect and impulses, 2) alterations in attention or consciousness; 3) alterations in self-perception, 4) alterations in relations with others, 5) somatization, and 6) alterations in systems of meaning; and symptom change over time. It shows acceptable to high rates of internal

consistency for the full scale (Cronbach $\alpha = .93$) and five subscales ($\alpha = .74$ to $.82$) indicating that these scales may be reliably interpreted in a continuous fashion. Scores on the Somatization subscale, however, should be interpreted with caution as the internal consistency level is only $\alpha = .68$ (Luxenburg et al., 2001). Validity of the full scale shows a correlation coefficient of $.86$ (van der Kolk et al., 1996). This tool can be used for diagnosis of Complex PTSD. Research participants who did not meet the diagnostic criteria for Complex PTSD as measured with the SIDES-SR in the beginning of therapy were excluded from the study.

The DES-T is an 8-item self-report screening instrument for pathological dissociation based on the DES. While the DES measures both pathological and non-pathological dissociation and therefore produces higher scores also for people without any trauma-related disorders, the DES-T is especially sensitive for diagnosing dissociation in PTSD, complex PTSD, and dissociative identity disorder (Wallner, Putnam & Carlsson, 1996). The test-retest-reliability for the DES-T in a non-clinical sample, however, only comes to $.34$ (Watson, 2003). It is therefore recommended to use this instrument only for clinical populations.

The SDQ-5 is a short version of the SDQ-20 which was designed to evaluate the severity of somatoform dissociation. The five items of the SDQ-5 as a group discriminated best between patients with dissociative disorders and non-dissociative psychiatric comparison patients (Nijenhuis et al., 1997b, 1998b). The SDQ-5 was more sensitive than the DES to assess dissociative pathology among patients with somatoform disorders (Nijenhuis et al. 1997a, 1997b, 1998a). The SDQ-5 can be used as a screening instrument for dissociative disorders (DD). The cut-off value for DD is ≥ 8 . "Sensitivity and specificity were high, positive predictive value corrected for prevalence of dissociative disorders, rated at 10% among psychiatric patients, was satisfactory, and prevalence-corrected negative predictive value was excellent." (Nijenhuis, 2003, p. 5)

The IIP-PD25 is a 25-item self-report measurement of interpersonal problems for patients with personality disorders. It covers interpersonal behavior which (a) is difficult for a

person, or (b) a person shows excessively. It consists of the five subscales of interpersonal sensitivity, interpersonal ambivalence, aggression, need for social approval, and lack of sociability. Internal consistency is tested as $\alpha = .80 - .88$. The instrument has predictive validity in the examination of personality disorders. (Hughes & Barkham, 2005)

The SOC – short version is a 13-item measurement of factors that promote improvement of health. The SOC in the full or short version has been used in GIM-studies measuring inner resources (Bonde, 2005; Körlin, Nybäck & Goldberg, 2000; Körlin & Wrangsjö, 2001, 2002; Wrangsjö & Körlin, 1995). Other than in the full version of the SOC, no sub-scales can be used in the SOC-13. The Cronbach α of the SOC-13 ranges from .70 to .92. (Eriksson & Lindström, 2005) The SOC in its full and short versions is intended to reflect a stable health potential which could not be influenced by negative life events or by therapy.

Test-retest correlation show stability and range from 0.69 to 0.78 (1 year), 0.64 (3 years), 0.42 to 0.45 (4 years), 0.59 to 0.67 (5 years) to 0.54 (10 years). The means of ... SOC-13 [range] from 35.39 (*SD* 0.10) to 77.60 (*SD* 13.80) points. After 10 years SOC seems to be comparatively stable, but not as stable as Antonovsky initially assumed. SOC tends to increase with age. (Eriksson & Lindström, 2005, p. 460)

Studies using GIM, however, show significant improvement on the subscales of meaningfulness and manageability of the long version of the SOC after treatment (Körlin & Wrangsjö, 2002). Also for patients with severe multiple traumatizations, the SOC-13 is not stable over time. For the traumatized population “SOC was closely associated with overall life satisfaction when measured simultaneously. Furthermore, a weak SOC correlated with scores on psychological distress, anxiety and depression. SOC scores were also significantly related to being or not being in a state of anxiety, but not to being or not being depressed.” (Snekkevik et al., 2003, p. 443) For patients with severe and multiple traumatizations, “SOC measured at admission could neither predict future satisfaction with life as a whole nor future psychological well-being.” (Snekkevik et al., 2003, p. 443)

In addition, patients filled out part I (personal information) and (for the treatment-groups) sections of part II (information about psychotherapy experience) of the KÖDOPS-Katamnesemodul (KÖDOKAT) by Fischer (2000), as well as questions about confounding variables like perpetrator contact during therapy. Patients of the treatment groups and of the control group did that at the last time they filled in questionnaires. Patients of the follow-up group filled in these questionnaires together with the rest of the questionnaires. At this time, patients of the treatment-groups were also asked if they would be willing to participate in an interview about their treatment for the qualitative part of the research.

Therapists filled in a brief questionnaire containing some demographic information, and information about their training and work experience. They also listed for each therapy session with each client the length of the session, which therapy interventions were used, and some specifics about the client at that time like medication, additional diagnoses, hospitalization (including reason and length of hospitalization), etc.

As different groups were compared at different times with confounding variables present, the statistics used were a multivariate ANOVA (MANOVA).

3.2.4 Hypotheses

To answer research question 1, and in part also research question 2, the following hypotheses were formulated:

1. Participants from the GIM group will report a greater improvement of symptoms of Complex PTSD than participants from the control group as measured by the SIDES-SR.
2. Participants from the PITT group will report a greater improvement of symptoms of Complex PTSD than participants from the control group as measured by the SIDES-SR.

3. Participants from the GIM follow-up group will report a similar or reduced level of symptoms of Complex PTSD compared to the GIM treatment group at posttest as measured by the SIDES-SR.
4. Participants from the GIM group will report a greater improvement of symptoms of structural dissociation than participants from the control group as measured by the DES-T.
5. Participants from the PITT group will report a greater improvement of symptoms of structural dissociation than participants from the control group as measured by the DES-T.
6. Participants from the GIM follow-up group will report a similar or reduced level of symptoms of structural dissociation compared to the GIM treatment group at post-test as measured by the DES-T.
7. Participants from the GIM group will report a greater improvement of symptoms of somatoform dissociation than participants from the control group as measured by the SDQ-5.
8. Participants from the PITT group will report a greater improvement of symptoms of somatoform dissociation than participants from the control group as measured by the SDQ-5.
9. Participants from the GIM follow-up group will report a similar or reduced level of symptoms of somatoform dissociation compared to the GIM treatment group at posttest as measured by the SDQ-5.
10. Participants from the GIM group will report a greater reduction of interpersonal problems than participants from the control group as measured by the IIP-PD25.
11. Participants from the PITT group will report a greater reduction of interpersonal problems than participants from the control group as measured by the IIP-PD25.
12. Participants from the GIM follow-up group will report a similar or reduced level of interpersonal problems compared to the GIM treatment group at posttest as measured by the IIP-PD25.

13. Participants from the GIM group will report a greater improvement in quality of life than participants from the control group as measured by the SOC.
14. Participants from the PITT group will report a greater improvement in quality of life than participants from the control group as measured by the SOC.
15. Participants from the GIM follow-up group will report a similar or improved quality of life compared to the GIM treatment group at posttest as measured by the SOC.

3.3 The Qualitative Part of the Study

3.3.1 Heuristic Research

When I was searching for a qualitative research method for this study, I was very aware of the fact that I was not just a person researching a phenomenon that interests me. I am not only a GIM-therapist and trainer, but I am also a trauma-survivor. I was struggling with Complex PTSD myself and I was helped with coping with it both through GIM therapy and other therapies. In ethnographic research authors speak about the danger that the researcher becomes native (Robson, 2002); in phenomenology and other qualitative research methods, it is important to bracket one's own experiences to become completely open for the research subject (Robson, 2002; Forinash & Grocke, 2005; Kenny et al., 2005). For a while I felt like a fish having to look at the meaning of water for fish from the perspective of someone living in the desert. I did not just feel difficult to keep this perspective for an extended period of time, but I also thought that as fish I have some important information about the meaning of water that I would have to withhold in the position of, for example, a camel. When I read about first-person research by Bruscia (2005) and heuristic research by Moustakas (1990), this approach appeared to be the solution for my problem: my personal experiences and reflections on them can be used as data for the research along with other persons' experiences and their reflections. Both can stand side by side without the one being "more true" than the other. It also felt more honest to me, because I do not think it would be really possible to bracket such a huge amount of my life.

Wilber (1995, 1996) stresses the importance of including the different perspectives of the Interior-Individual, the Interior-Collective (cultural), the Exterior-Individual and the Exterior-Collective (social) into a holistic view of the cosmos and the phenomena in it. Heuristic research uses the concepts of reflection and meaning to inquire into the interior – both individual and collective (Bruscia, 2005; Moustakas, 1990). It can be used to just inquire into the researcher's inner self as the only source of data. Moustakas (1990), however, recommends using interviews with research participants who have intimate knowledge of the phenomenon as additional sources of data.

For this study, I used heuristic research as described by Moustakas (1990). It always starts with formulating the research questions and defining its primary terms and meanings. After that, "methods ... are open-ended. They point to a process of accomplishing something in a thoughtful and orderly way that guides the researcher. There is no exclusive list that would be appropriate for every heuristic investigation, but rather each research process unfolds in its own way." (Moustakas, 1990, p. 43) However, the author describes six phases of heuristic research, and gives guidelines for data-analysis.

The six phases of research which again are used in the different stages of the research are initial engagement, immersion, incubation, illumination, explication, and creative synthesis. These phases guide the thought process of the researcher, her way of being with the research topic or a detail of it, and even her attitude towards the research process itself. "The task of the initial engagement is to discover an intense interest, a passionate concern that calls out to the researcher ... The initial engagement invites self-dialogue, an inner search to discover the topic and question." (Moustakas, 1990, p. 27) During the following phase of immersion

the researcher lives the question in waking, sleeping, and even dream states. Everything in ... her life becomes crystallized around the question. The immersion process enables the researcher to come to be on intimate terms with the question – to live it and grow in knowledge and understanding of it. ... Primary concepts for facilitating the immersion process include spontaneous self-dialogue

and self-searching, pursuing intuitive clues or hunches, and drawing from the mystery and sources of energy and knowledge with the tacit dimension. (Moustakas, 1990, p. 28)

Tacit knowing here is described as a basic capacity of the self that “gives birth to the hunches and vague, formless insights that characterize heuristic discovery. ... All knowledge is either tacit or rooted in tacit knowledge.” (Moustakas, 1990, p. 22) The phase of immersion is followed by a phase of incubation in which the researcher retreats from the conscious and direct immersion into the question or phenomenon and deals with other things in her life. The goal of incubation is to allow the collected knowledge to develop further on a deeper level. This could be like being pregnant with the knowledge but not doing anything with it except giving it time and space to grow and develop inside. Illumination is something that comes naturally out of this. It is a breakthrough into conscious awareness. “Illumination opens the door to a new awareness, a modification of an old understanding, a synthesis of fragmented knowledge, or an altogether new discovery of something that has been present for some time yet beyond immediate awareness.” (Moustakas, 1990, p. 30) In the following phase of explication the researcher fully examines what has come into consciousness.

In the explication process, the heuristic researcher utilizes focusing, indwelling, self-searching, and self-disclosure, and recognizes that meanings are unique and distinctive to an experience and depend upon internal frames of reference. The entire process of explication requires that researchers attend to their own awareness, feelings, thoughts, beliefs, and judgments as a prelude to the understanding that is derived from conversations and dialogues with others. (Moustakas, 1990, p. 31)

Finally the researcher has to put all components and core themes into a creative synthesis which can take the form of a narrative or any other creative form.

Moustakas (1990) gives the following guidelines for data-analysis:

1. Gathering all data from one research participant. (A research participant can also be the researcher herself.)
2. Entering into the material in timeless immersion until it is understood both as a whole and in its details.
3. A period of incubation follows. Then the material is reviewed again and the researcher takes notes, identifying the qualities and themes manifested in the data. This enables the researcher to write an individual depiction of the experience. The individual depiction includes qualities and themes of the experience, and examples from the interview are given.
4. Returning to the original data of the participant and checking if the individual depiction fits the original data and if it contains all important qualities and themes. If no: revising the individual depiction. Sharing the individual depiction with the research participant for affirmation of comprehensiveness and accuracy and for suggested deletions and additions.
5. The same steps are taken for every other individual research participant.
6. Immersion into all individual depictions with intervals of incubation until the universal qualities and themes of the experience are understood. Writing a composite depiction that represents the common qualities and themes of the experience including examples from the data material.
7. Returning to the raw data of all participants and the individual depictions, the researcher chooses two or three participants who exemplify the group as a whole. The researcher develops individual portraits of these participants.
8. Developing a creative synthesis of the experience. The creative synthesis “invites a recognition of tacit-intuitive awarenesses of the researcher, knowledge that has been incubating over months through processes of immersion, illumination, and explication of the phenomenon investigated. The researcher as scientist-artist develops an aesthetic rendition of the themes and essential meanings of the phenomenon. The researcher taps into imaginative and contemplative sources of

knowledge and insight in synthesizing the experience, in presenting the discovery of the essences ...” (Moustakas, 1990, p. 52)

Douglas and Moustakas (1985) compared heuristic research with phenomenological research. It was contrasted as follows:

(1) Whereas phenomenology encourages a kind of detachment from the phenomenon being investigated, heuristics emphasize connectedness and relationship. (2) Whereas phenomenology permits the researcher to conclude with definitive descriptions of the structures of experience, heuristics leads to depictions of essential meanings and portrayal of the intrigue and personal significance that imbue the search to know. (3) Whereas phenomenological research generally concludes with a presentation of the distilled structures of experience, heuristics may involve reintegration of derived knowledge that itself is an act of creative discovery, a synthesis that includes intuition and tacit understanding. (4) Whereas phenomenology loses the persons in the process of descriptive analysis, in heuristics the research participants remain visible in the examination of the data and continue to be portrayed as whole persons. Phenomenology ends with the essence of experience; heuristics retains the essence of the person in experience. (Douglas & Moustakas, 1985, p. 43)

3.3.2 Qualitative Methodology

The purpose of the qualitative part of the study was to answer the following questions:

1. For the patients treated with GIM: How did the patients work with the music? What role did the music play?
2. How did the patients work with the imagery? What role did the imagery play?
3. What in their therapies actually helped the patients, what was hindering as perceived by the patients (including aspects of the therapeutic relationship)?
4. Were there any perceived turning points? What were they like?

5. What were the patients perceived outcomes of their therapies?
6. How did it correspond with the quantitative part?
7. Did it add other outcomes?
8. Did it contradict?
9. Did it clarify quantitative outcome?

Using Moustakas' (1990) method of heuristic research, this part again is divided into two intertwining sections: 1. the researcher's reflections and insights into the topic, and 2. semi-structured interviews with five purposively chosen research participants from each of the two treatment groups who volunteered for an interview. For her own reflections, the researcher used Moustakas' six phases of research described under 3.3.1. For the phases of Immersion and Illumination, in addition to the possibilities described by Moustakas (1990, p. 28ff) a technique based on Bruscia's (1998) Re-imaging was used. Re-imaging is defined by Bruscia (2002a) in the following way:

In re-imaging, one person has a short GIM session focused on exploring a previous imagery experience of another person. The technique is used in individual, couple, and group settings, for clinical or supervisory purposes. The sessions are guided in individual and couple settings, but unguided in group settings. (Bruscia, 2002a, p. 51)

For research, a modification of Re-imaging can be used especially when answering the above mentioned questions 1. and 2. The researcher proceeded in the following way:

1. Thinking back of some of her own sessions in which either music or imagery was especially important
2. Writing a short paragraph about each of these sessions.
3. Reflecting on the meaning of either music or imagery in these particular sessions.
4. Choosing the most important piece of music from the session or the most important imagery sequence.
5. The guide chosen for the Re-imaging spoke a short induction similar to GIM-inductions with the focus on the imagery sequence chosen.

6. The guide used the chosen music from the original session. The researcher imagined that she was either the music or part of the imagery and spoke from that place, starting for example with “I am the music.”¹⁰ The guide used similar verbal interventions as in GIM but with a clear focus on the topic. He also transcribed the Re-imagining session.
7. The Re-imagining sessions were then further analyzed according to Moustakas design described under 3.3.1.

The main differences to Re-imagining as described by Bruscia is that the researcher re-imagines one of her own imagery sequences, but from a different perspective; and that the purpose here is research.

The researcher conducted semi-structured interviews with five research participants from each of the two treatment groups. If possible research participants were given options of in-person interviews, telephone-interviews, or writing answers to the questions. It could also be a mix of different interview styles, for example in-person interview but the research participants adds things in writing. Giving the research participants choices was chosen to make them feel more comfortable and in control during the interview. The interviews were analyzed according to Moustakas’ design of heuristic research described under 3.3.1.

3.3.3 Participants and Collection of Data

The research participants of the qualitative part of the study came from the quantitative part. In the posttest questionnaires for the GIM and the PITT treatment groups, and in the questionnaires for the GIM follow-up group, participants were asked if they would be willing to take part in an interview about their therapy experiences. About 35 % of the participants in the quantitative part of the study agreed to be interviewed. When choosing the participants for the interviews, I looked for differences in education and marital status. I also tried to have clients of different therapists. For the participants who had GIM therapy, I

¹⁰ The idea of identifying with different therapeutic parts of the session was also inspired by my supervision teachers Johan Lansen and Ton Haans who used it in group-supervision. For a description of that see “Clinical Supervision for Trauma Therapists” (Lansen & Haans 2004).

wanted some from the treatment and some from the follow-up group, and I was looking for participants from different countries. All interviews were done either in person or by telephone, and they took 1-2 hours each. In the following I give brief introductions to the research participants:

3.3.3.1 Participants from the GIM Groups

E is in her 50s and from Germany. She is married and has two adolescent children, both from her husband. She is a mother and housewife. Before she got her children, she used to work as a secretary. She had 46 GIM sessions, 2 hours each, imbedded into verbal psychodynamic psychotherapy with a female psychotherapist and music therapist. Her last session was about 2 years ago.

Before her GIM therapy, she had had a number of shorter therapies with different therapists. All of them she broke off after some sessions because she felt misunderstood and mistreated by these therapists. She said that none of them was looking at her traumatizations or even considered trauma-therapy. The only other psychotherapist who had helped her was a couples-therapist whom she had consulted together with her husband for marital problems. This therapist also did not look at the traumatizations, but she had helped her and her husband with their partnership.

H is in her 30s and from Germany. She is divorced and has one child, from her ex-husband. She separated from him because he got physically violent against her and their little son. She grew up in former East Germany. H is a student of sociology. She had 40 sessions of GIM, each two hours long, imbedded into ongoing weekly psychodynamic psychotherapy with a female psychotherapist. She started therapy because she wanted to work on her history of abuse. H had no previous experience with psychotherapy.

M is in her 40s and from Sweden. She is married and has two adult children, both from her husband. She is employed as music therapist. She had 10 sessions of weekly GIM therapy – each session was 2 hours long – with a male psychiatrist and psycho-

therapist. This therapy took place about 550 km away from her hometown. Her last session was about 8 years ago. In addition she had one hour of analytical psychotherapy per week with a local male psychoanalyst. This therapy started before her GIM therapy. When she started GIM, she had the feeling that she had gotten stuck in her verbal psychotherapy.

Three years before this verbal psychotherapy, she had five hours of verbal psychotherapy with a different therapist. She had stopped this therapy, because she felt that it was too much. She had felt drained, empty, and like a bad person after the sessions, and she did not trust the therapist.

U is in her 40s and from the United States. She is married but has no children. She is an accountant. U had 19 sessions of bi-weekly GIM therapy (1 hour per session in the earlier phases of therapy, and 2 hours per session later) with a female counselor. The therapy is ongoing. In addition she had one hour of psychodynamic psychotherapy per week with a psychiatrist. This therapy started before her GIM therapy. When she started GIM, she had the feeling that she had gotten stuck in her verbal psychotherapy.

3.3.3.2 Participants from the PITT Group

C is in her 40s and from Germany. She is living alone but has a partner for 5 years who is living nearby. She has no children. C is a social worker. She had 59 hours of psychodynamic therapy with PITT embedded into it for one hour per week with her current therapist. Her therapist is female. Before this therapy, she had two other psychotherapies, one about 5 and one about 15 years ago. It was difficult for her to find a trauma therapist, and before she could start her therapy she had to wait for about 9 months. She said that the time of waiting was really difficult for her and her symptoms got much worse during that time.

K is in her late 20s and from Germany. She is married to an alcoholic husband with whom she has four children. Both she and her husband are unable to work due to their psychological problems. They get social welfare. K got her first child when she was

16. She has a 9th grade education, and in the past she worked as an assistant in a retirement home. Besides her psychotherapy she has consultations with a psychiatrist every other month for 20 minutes for medication. She and her husband have help with the children. Social workers from the youth welfare office come regularly to spend time with one or more of the children. K had to wait more than a year for her psychotherapy. It is her first psychotherapy. She has weekly psychotherapy sessions which last 50 minutes each with a male psychotherapist. At the time of the interview she had 55 sessions of psychodynamic psychotherapy in which PITT is embedded.

N is in her 30s and from Germany. She is living alone and has no partner or children. She is very unhappy about this situation. N is a teacher. She had 62 hours of psychodynamic therapy, one hour per week with her current therapist. PITT is embedded into it. Her therapist is female. Before this therapy, she had one other psychotherapy right before the current therapy. She had to leave her former therapist when N moved to another part of Germany. Her first therapist helped her to find a colleague in the city N lives in now. Because of that and because N is privately insured, she did not have to wait for her therapy. N's first therapist did not use PITT but did trauma therapy with a psychodynamic background. N's current therapist also has a background in psychodynamic and also Gestalt therapy. Besides her Complex PTSD, N is suffering from a severe visual impairment and from endometriosis.

S is in her mid 40s. She is divorced and lives alone with her school-age son. S has a new partner. S could not finish her studies at the university due to health reasons. Currently she is still unable to work. Besides her Complex PTSD, S is also suffering from a number of physical illnesses, some of them being irreversible and eventually fatal. She is with her current female therapist for two years now. In the beginning of therapy she had one weekly session of 50 minutes, now she has two sessions per week. PITT is embedded into psychodynamic therapy. S had to wait a year before she could start therapy. About 20 years ago, she had been in psychoanalysis with a male therapist for a while.

J is in her 50s and trained as a psychologist. Due to her health problems, however, she was never able to work. J is retired, lives alone and has no children. J was hospitalized twice for psychological reasons, and about 10 years ago, she was in psychoanalysis for four years with a female analyst. With her current therapist J is for two years now. In this therapy PITT is embedded into psychodynamic psychotherapy. She has one psychotherapy session of 50 minutes per week.

3.3.4 Researcher's Context

I decided to put this section here because I believe that my personal context has more implication on the qualitative part of the study than on the quantitative one. I am a GIM-therapist and trainer assuming that GIM is a valuable therapy. As GIM-therapist I have worked a lot with survivors of trauma and saw that the method was very helpful if it was embedded into trauma-therapy and if state-of-the-art guidelines for trauma-therapy were observed. I also saw that for some trauma-survivors GIM or its adaptations did not work, usually because for them music brought up too many difficult emotions too quickly. However, I do not see yet any patterns for which trauma-survivors GIM and its adaptations work and for which it does not work. I hoped that this study might clarify this a bit more.

I am also a trauma-survivor struggling with Complex PTSD. For that I was treated with different kinds of psychotherapy, also with GIM and its adaptations but not with PITT. In general I noticed that different kinds of therapy were helpful for me in different stages, and that some ways of conducting therapy were more helpful than others. I believe that different kinds of psychotherapy may help trauma-survivors, and that there is not just one single method of choice. I was in treatment with different GIM-therapists from different countries. Some of these treatments I would rate between helpful and very successful, one treatment was harmful. The degree to which GIM-treatment was helpful or harmful for me depended mainly on the therapeutic relationship. In the harmful treatment, the therapist was not abstinent but engaged in exploitive multiple relationships. I

found that the more knowledge the GIM-therapist had about trauma and trauma-therapy, and the more he was accompanying me in my own healing process without either trying to rescue me or pushing me and my (trauma-)story away, the more helpful was the therapy for me.

Music played an important role, both in my private and in my professional life. In my childhood and adolescence music was one of the few possibilities for expressing my emotions. Professionally I was first trained as a musician, then as a music therapist. If I had the choice whether to do imagery-based therapy with or without music as client or therapist, I would certainly choose for music. Even when one of my GIM-therapists became abusive, GIM as a method and music in particular were helpful for me because music and imagery were still there for me while the therapist was not, and the inner process with music and imagery – even though I could not share it anymore with the therapist – helped me to leave the exploitive therapeutic relationship. On the other hand I am aware that music may not be as important for other persons.

As mentioned before, I never had direct experiences with PITT, neither as client nor as therapist. My experiences with PITT are limited to reading about it, presentations at conferences and talking with a few colleagues who are trained in the method. My personal feeling from that is that PITT is a good method for traumatized clients. I especially like the respectful attitude towards the client and the creativity inherent in the imagery.

This is a heuristic study where the researcher and the research participants have very similar characteristics: I am a female trauma-survivor who suffered from Complex PTSD and was treated with GIM therapy and other therapies. Because of that, this study can give different perspectives from the inside of the phenomenon under study, but no outside perspective. It could happen that some aspects may not have been seen because the researcher and the research participants were too close to the studied phenomenon. Things might not have been named because they appear too “normal” while an outsider might not find them normal at all.

In summary, I hold the following assumptions that may influence the study:

1. I believe that both GIM and its adaptations, and PITT may be effective therapies for the treatment of Complex PTSD.
2. I believe that music can be an important and very healing part of therapy. However, there are clients for whom music can be overwhelming.
3. I believe that the therapeutic relationship is more important for the outcome of trauma-therapy than the therapeutic method.
4. I believe that the therapist's knowledge about trauma and state-of-the-art trauma-therapy is important for the success of the therapy.
5. This study looked at a phenomenon from the inside. Some things that an outsider might find important may not have been seen because of the closeness to the phenomenon under study.

3.4 Ethics

The participating patients in this study addressed issues where they needed the security of trust, clarity, and the right to say no to anything they do not feel acceptable. Therefore ethical precautions were given very careful consideration and importance. Consent has been obtained from the participating therapists and their patients through a signed letter (see Appendix B). This procedure applied to patients in all four groups.

The participation in the study was completely voluntary for participating therapists and patients. Both therapists and patients could withdraw from the study at any time. If a patient decided to drop out of the study, it did not influence her therapy in any way. In order to answer confidentiality, the informed consent forms signed by the patients were kept by the therapists, so that the researcher did not know the name and address of any of the participating patients.

The participating patients attended therapy in the usual way, and they were not referred to therapy for the purpose of this research study. The treatment applied is standard GIM and its adaptations or PITT-treatment. It was not changed, adapted, modified or manipulated in any way for the research.

The questionnaires for the quantitative research were coded to ensure confidentiality both to therapists and patients. The individual questionnaires were available only to the main researcher and her supervisors. No questions within the questionnaires asked for actual information about traumatizations, but only for details of existing symptoms.

Participants in the qualitative part of the study could answer questions in writing, in a telephone interview, or in a personal interview according to what they preferred. If participants gave their name or other identifying information during the process, it has only been available to the main researcher who kept it confidential. This information was destroyed once the study was completed.

The control-group consisted of patients on existing waiting lists. No treatment has been withheld for the purpose of the study.

Chapter 4: RESULTS

4.0 Introduction

The aim of the Results Chapter is to give an overview of the outcomes of the study. In the first part, the quantitative results are reported while the second part contains the results from the qualitative interviews and my own reflections on the topic.

4.1 Results of the Quantitative Investigation

4.1.1 Introduction

In this chapter the results of the quantitative investigation are displayed. The goal for that is to address research questions 1 and 2 of this study:

Research question 1:

When would GIM and when would PITT be indicated?

Research question 2:

Is either or both of these methods indicated for severely traumatized adult patients?

Research question 1 will also be addressed in the qualitative part of the study.

In the first part, the effects of GIM and PITT treatment are compared to each other and to the control group. In the second part long-term effects of GIM therapy are reported by comparing the post-treatment results of the GIM group with a separate but matched follow-up group who had finished GIM therapy at least one year ago. Both parts start with looking at the distribution of data, matching of the groups and possible covariates before proceeding to the results from the questionnaires.

4.1.2 Effects of GIM and PITT Treatment Compared to the Control Group

In this section the results from the questionnaires from the GIM treatment group, the PITT group and the control group are compared. The section starts with the preparations for data analysis: looking at the distribution of data at pretest, checking in which areas the three groups match and where they do not match, and determining covariates. Then the actual data analyses are presented in the areas of symptoms of Complex PTSD (SIDES-SR), dissociation (DES-T and SDQ-5), interpersonal problems (IIP-PD25), and sense of coherence (SOC-13).

4.1.2.1 Distribution of Data, Matching of Groups and Covariates

In this section, the steps are described that were taken before the actual data analysis could be conducted. These were (a) checking the distribution of data of the whole sample at pretest, (b) checking where groups match and where they do not match, and (c) checking if any of the areas the groups do not match are covariates.

After having evaluated all questionnaires given out before the actual treatment started for the PITT and the GIM treatment groups and at the beginning of the waiting time for the control group, Normal Q-Q Plots were made for the results of each of the questionnaires. The Q-Q Plots showed that for each questionnaire there is a normal distribution of data at pretest. Therefore no transformation of data was necessary.

As a next step, I checked in which areas the two treatment groups and the control group matched, and in which they do not match. For nominal data, chi-squares were calculated to determine whether the groups matched or not, for scales and ordinal data ANOVAs were calculated. The groups match in the following areas:

- Age of participants
- Marital status
- Preference for gender of the therapist
- Perpetrator contact during therapy

Especially the last two areas are important for psychotherapy in general and for trauma therapy. All participants of the study either had a therapist of the preferred gender, or the gender of the therapist was not important for the participant. In the area of perpetrator contact during therapy, the following distribution was reported:

Table 4.1: Perpetrator Contact during Therapy by Group

Therapy	Perpetrator Contact			χ^2	df	p
	yes	no	no answer			
Guided Imagery and Music	18	16	0	1.924	2	0.382
Psychodynamic Imaginative Trauma Therapy	20	10	4			
Control	23	11	0			

The table shows that in all groups there were more participants having perpetrator contact than participants not having perpetrator contact during their therapies or waiting time.

The groups did not match in the following areas:

- Nationalities of participants
- Employment situation
- Results of the SIDES-SR, DES-T, IIP-PD25, and SOC-13 at pretest

Due to the fact that there are only very few GIM therapists in one single country, therapists from around the world were included, which is also reflected in the nationalities of the participants. PITT on the other hand was only used in Germany and Switzerland at the beginning of the study, so most of the participants' nationalities are from these countries. In the control group there are only participants who live in Germany, because Germany is one of the few countries that has very long waiting times for psychotherapy and especially for trauma therapy. The nationalities of the participants are displayed in Table 4.2.

Table 4.2: Nationalities of participants

Nationality	Number of participants from the Guided Imagery and Music group	Number of participants from the Psychodynamic Imaginative Trauma Therapy group	Number of participants from the control group	X^2	df	p
German	8	28	29	82.954	12	< 0.001
Swiss		5				
Swedish	5					
Spanish		1	2			
Turkish			3			
Croatian	1					
US American	20					

The next area in which the groups do not match is the employment situation of the participants at pretest. The control group had more unemployed participants but fewer participants who stay at home with their children.

The last area in which the three groups did not match is the results of the questionnaires at pretest time. The following table gives an overview:

Table 4.3: Results of Questionnaires at Pretest

Questionnaire	Therapy	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
SIDES-SR	Guided Imagery and Music	1.47	0.19	17.67	<
	Psychodynamic Imaginative	1.29	0.30	(2,99)	0.001
	Trauma Therapy				
	Control	1.09	0.29		
DES-T	Guided Imagery and Music	30.48	11.03	4.70	0.011
	Psychodynamic Imaginative	17.66	20.77	(2,99)	
	Trauma Therapy				
	Control	23.71	18.43		
SDQ-5	Guided Imagery and Music	9.41	2.80	0.10	0.907
	Psychodynamic Imaginative	9.03	3.66	(2,99)	
	Trauma Therapy				
	Control	9.18	4.20		
IIP-PD25	Guided Imagery and Music	36.59	13.83	26.50	<
	Psychodynamic Imaginative	57.93	12.00	(2,99)	0.001
	Trauma Therapy				
	Control	40.71	12.57		
SOC-13	Guided Imagery and Music	43.29	6.84	8.70	<
	Psychodynamic Imaginative	45.03	12.17	(2,99)	0.001
	Trauma Therapy				
	Control	53.53	12.52		

For all groups $n = 34$

The table shows that the groups were equal at pretest only on scores for the SDQ-5. The three groups were significantly different on scores from the SIDES-SR, DES-T, IIP-PD25, and SOC-13.

In the area of the highest academic degree of the participants the groups were not significantly different, but the difference approached significance. Results are displayed in Table 4.4.

Table 4.4: Academic Degrees of participants

	DEGREE				χ^2	df	p
	none	less than high-school diploma or international equivalent	high-school diploma or international equivalent	university degree			
Guided Imagery and Music		6	12	16	11.135	6	0.084
Psychodynamic Imaginative		14	9	11			
Trauma Therapy							
Control	3	11	8	12			

In the GIM group, more participants have at least a high-school diploma or international equivalent and more participants have a university degree than in the other two groups.

To check whether any of the areas in which the groups did not match at pretest should be used as a covariate, correlations between these variables and the pretest measures of the questionnaires through therapy or waiting were computed. No significant correlations were found between therapy outcome and the employment situation or the academic degree of the participants. A correlation, however, was found between therapy outcome and the results of the questionnaires at the time of pretest. The pretest scores of the questionnaires – except for the SDQ-5 scores where the groups matched at pretest – were used as covariates. Significant correlations were found between nationality and the pretest measures of the SIDES-SR ($\rho = .244$, $p = .013$), between nationality and the pretest measures of the DES-T ($\rho = .304$, $p = .002$), and between nationality and the pretest measures of the IIP-PD25 ($\rho = .380$, $p < .001$). Nationality was used as a second covariate when computing the outcomes of the SIDES-SR, the DES-T, and the IIP-PD25.

4.1.2.2 Effects on Symptoms of Complex PTSD: SIDES-SR

The SIDES-SR is the main measurement instrument in this study. It can be used for diagnosing Complex PTSD, and for tracking symptom severity over the course of treatment. For each of the research participants of the GIM treatment group, the PITT treatment group, and the control group, a diagnostic scoring of the SIDES-SR at pretest was conducted. All of the participants from all three groups fulfilled the diagnostic criteria for Complex PTSD as described in the Trauma Center Assessment Package (Trauma Center, 2003) and in Fischer (2000).

For calculating outcome, symptom severity scoring was used: The total score of the questionnaire was taken and divided by the number of items. Before calculating outcome measures, homogeneity of variance was tested. Levene's test was significant showing that there was a difference in the variances among the three groups. Arithmetic transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.5.

Table 4.5: Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress by Group

	Pretest			Posttest			χ^2	df	p
	m	Min.	Max.	m	Min.	Max.			
Guided Imagery and Music	1.47	0.96	1.98	0.28	0.07	1.16	85.136	2	<
Psychodynamic Imaginative Trauma Therapy	1.34	0.67	1.96	0.88	0.36	2.18			0.001
Control	1.03	0.60	1.87	1.64	0.96	2.42			

n = 34 per group; Min. = Minimum; Max = Maximum

The table shows that participants treated with GIM or PITT improved while the severity of symptoms worsened for the participants of the control group. A Kruskal-Wallis-Test shows that there was a significant difference in change of severity of symptoms between the groups ($p < .001$). Through Mann-Whitney Tests it could also be shown that there were significant differences in change of severity of symptoms between the GIM and the control group ($U < .001$, $p < .001$), between the PITT and the control group ($U = 36.00$, $p < .001$),

and between the GIM and the PITT group ($U = 25.00$, $p < .001$). The symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group.

After looking at the SIDES-SR as a whole, we now come to the six individual subscales. The first subscale measures alterations in regulation of affect and impulses. Also here, homogeneity of variance was tested. Levene's test was significant showing that there was a difference in the variances among the three groups. Arithmetic transformation of the data could not solve the problem, therefore nonparametric statistics were used. Medians and ranges are shown in Table 4.6.

Table 4.6: Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale "Alterations in Regulation of Affect and Impulses" by Group

	Pretest			Posttest			X^2	df	p
	m	Min.	Max.	m	Min.	Max.			
Guided Imagery and Music	1.16	0.68	1.95	0.16	0.05	1.31	68.373	2	<
Psychodynamic Imaginative	1.36	0.32	1.74	0.68	0.37	2.16			0.001
Trauma Therapy									
Control	.95	0.53	1.79	1.53	0.74	2.53			

$n = 34$ per group; Min. = Minimum; Max = Maximum

The table shows that participants treated with GIM or PITT improved while the severity of symptoms worsened for the participants of the control group. A Kruskal-Wallis-Test shows that there was a significant difference in change of severity of symptoms of alterations in regulation of affect and impulses between the groups ($p < .001$). Through Mann-Whitney Tests it could also be shown that there were significant differences in change of severity of symptoms between the GIM and the control group ($U < .001$, $p < .001$), between the PITT and the control group ($U = 118.50$, $p < .001$), and between the GIM and the PITT group ($U = 181.50$, $p < .001$). The symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group.

The second subscale measures amnesia and dissociation. For this subscale, equality of variances in different samples was found. Means and standard deviations are shown in Table 4.7.

Table 4.7: Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Amnesia and Dissociation” by Group

	Pretest		Posttest		<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Guided Imagery and Music	1.62	0.38	0.56	0.44	89.262	<
Psychodynamic Imaginative Trauma	1.35	0.53	0.88	0.63	(2,99)	.001
Therapy						
Control	1.23	0.32	1.90	0.50		

n = 34 per group

The table shows that participants treated with GIM or PITT improved while the severity of symptoms worsened for the participants of the control group. A test of between-subjects effects shows a significant difference in severity of symptoms of dissociation and amnesia among the three groups ($p < .001$). A post-hoc test was used to check where the results are significant. Tukey HSD shows that there were significant differences in change of severity of symptoms between the GIM and the control group ($p < .001$), between the PITT and the control group ($p < .001$), and between the GIM and the PITT group ($p < .001$). The symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group.

The third subscale measures alterations in self-perception. Levene’s test was significant showing that there was a difference in the variances among the three groups. Arithmetic transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.8.

Table 4.8: Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Alterations in Self-Perception” by Group

	Pretest			Posttest			χ^2	df	p
	m	Min.	Max.	m	Min.	Max.			
Guided Imagery and Music	1.67	1.00	2.50	.17	0.00	1.17	67.551	2	<
Psychodynamic Imaginative Trauma Therapy	1.67	0.67	2.33	1.33	0.33	2.67			0.001
Control	1.33	0.50	2.33	1.83	0.67	2.67			

$n = 34$ per group; Min. = Minimum; Max = Maximum

The table shows that participants treated with GIM or PITT improved while the severity of symptoms worsened for the participants of the control group. A Kruskal-Wallis-Test shows that there was a significant difference in change of severity of symptoms of alterations in self-perception between the groups ($p < .001$). Through Mann-Whitney Tests it could also be shown that there were significant differences in change of severity of symptoms between the GIM and the control group ($U < .001$, $p < .001$), between the PITT and the control group ($U = 207.00$, $p < .001$), and between the GIM and the PITT group ($U = 98.00$, $p < .001$). The symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group.

The fourth subscale measures alterations in relations with others. Levene’s test was significant showing that there was a difference in the variances among the three groups. Arithmetic transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.9.

Table 4.9: Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Alterations in Relations with Others” by Group

	Pretest			Posttest			X^2	df	p
	m	Min.	Max.	m	Min.	Max.			
Guided Imagery and Music	1.80	0.80	2.20	0.40	0.00	1.20	78.095	2	<
Psychodynamic Imaginative Trauma Therapy	1.40	0.60	2.50	1.00	0.20	2.20			0.001
Control	1.00	0.60	2.00	1.60	1.00	2.80			

$n = 34$ per group; Min. = Minimum; Max = Maximum

The table shows that participants treated with GIM or PITT improved while the severity of symptoms worsened for the participants of the control group. A Kruskal-Wallis-Test shows that there was a significant difference in change of severity of symptoms of alterations in relations with others between the groups ($p < .001$). Through Mann-Whitney Tests it could also be shown that there were significant differences in change of severity of symptoms between the GIM and the control group ($U = 2.00$, $p < .001$), between the PITT and the control group ($U = 107.00$, $p < .001$), and between the GIM and the PITT group ($U = 42.50$, $p < .001$). The symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group.

The fifth subscale measures somatization. For this subscale, equality of variances in different samples was found. Means and standard deviations are shown in Table 4.10.

Table 4.10: Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Somatization” by Group

	Pretest		Posttest		F	p
	M	SD	M	SD		
Guided Imagery and Music	1.19	0.46	0.22	0.27	61.303	< 0.001
Psychodynamic Imaginative Trauma Therapy	1.25	0.79	0.99	0.78	(2,99)	
Control	1.04	0.46	1.42	0.42		

$n = 34$ per group

The table shows that participants treated with GIM or PITT improved while the severity of symptoms worsened for the participants of the control group. A test of between-subjects effects shows a significant difference in severity of symptoms of somatization among the three groups ($p < .0001$). A post-hoc test was used to check where the results are significant. Tukey HSD shows that there were significant differences in change of severity of symptoms between the GIM and the control group ($p < .001$), between the PITT and the control group ($p < .001$), and between the GIM and the PITT group ($p < .001$). The symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group.

The sixth subscale measures disruptions in systems of meaning. Levene's test was significant showing that there was a difference in the variances among the three groups. Arithmetic transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.11.

Table 4.11: Medians and Ranges for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale "Disruptions in Systems of Meaning" by Group

	Pretest			Posttest			X^2	df	p
	m	Min.	Max.	m	Min.	Max.			
Guided Imagery and Music	2.00	0.20	2.80	0.20	0.00	1.00	73.671	2	< 0.001
Psychodynamic Imaginative	1.20	0.20	2.00	0.40	0.00	2.40			
Trauma Therapy									
Control	1.00	0.20	2.40	2.20	0.60	2.80			

$n = 34$ per group; Min. = Minimum; Max = Maximum

The table shows that participants treated with GIM or PITT improved while the severity of symptoms worsened for the participants of the control group. A Kruskal-Wallis-Test shows that there was a significant difference in change of severity of symptoms of disruptions in systems of meaning between the groups ($p < .001$). Through Mann-Whitney Tests it could also be shown that there were significant differences in change of severity of symptoms between the GIM and the control group ($U = 1.50$, $p < .001$), between the PITT and the control group ($U = 111.00$, $p < .001$), and between the GIM and the PITT group ($U =$

108.50, $p < .001$). The symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group.

It can be seen that for the whole SIDES-SR and all the subscales, severity of symptoms of Complex PTSD was significantly reduced in both the GIM and the PITT group compared to the control group. And severity of symptoms of Complex PTSD was reduced significantly more for participants of the GIM group compared to participants of the PITT group.

4.1.2.3 Effects on Dissociation: DES-T and SDQ-5

Two instruments were used to measure dissociation: the Dissociative Experiences Scale Taxon (DES-T) measuring structural dissociation, and the Somatoform Dissociation Questionnaire in its short version (SDQ-5) looking at dissociative phenomena in the body. First I present the results of the DES-T, and then the results of the SDQ-5.

The lowest possible score of the DES-T is zero, meaning that at no time the participant is experiencing dissociative symptoms. The highest possible score is 100, meaning that the participant is experiencing all the dissociative symptoms mentioned in the questionnaire all the time. For the DES-T, equality of variances in different samples was found. Means, standard deviations, pre-post correlations, and effect size are shown in Table 4.12.

Table 4.12: Means, Standard Deviations, Pre-Post Correlations, and Effect Size for Scores on the Dissociative Experiences Scale Taxon by Group

Group	Pretest		Posttest		Pre- Post <i>r</i>	Cohen's <i>d</i>	<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
Guided Imagery and Music	30.48	11.03	6.43	8.16	0.518	2.553	53.493 (2,99)	< .001
Psychodynamic Imaginative Trauma Ther- apy	17.66	20.77	13.20	20.61	0.833	0.373		
Control	23.71	18.43	36.21	17.77	0.730	-0.940		

n = 34 per group

The table shows that the severity of structural dissociation in participants treated with GIM or PITT is reduced while the severity of symptoms worsened for the participants of the control group. For the GIM and the PITT groups, Cohen's *d* was computed. In the table it can be seen that PITT has a small to medium effect size while GIM has a very large effect size. Having to wait at least nine months for therapy has a large negative effect size.

A test of between-subjects effects shows a significant difference in severity of symptoms of structural dissociation among the three groups ($p < .001$). A post-hoc test was used to check where the results are significant. Tukey HSD shows that there were significant differences in change of severity of symptoms between the GIM and the control group ($p < .001$), between the PITT and the control group ($p < .001$), and between the GIM and the PITT group ($p < .001$). The symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group. The effect size of GIM vs. PITT is 1.81 which is a very large effect size.

For all three measurement points, Box's test was significant showing that there was a difference in the variances between the two groups receiving therapy. Arithmetic

transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.13.

Table 4.13: Medians and Ranges for Scores on the Dissociative Experience Scale Taxon by Group

	Pretest			Mid-point			Posttest			χ^2	<i>df</i>	<i>p</i>
	<i>m</i>	Min.	Max.	<i>m</i>	Min.	Max.	<i>m</i>	Min.	Max.			
GIM	29.38	7.50	48.75	10.00	2.50	52.50	2.50	1.25	31.25	56.581	2	< 0.001
PITT	11.25	0.00	86.67	8.13	0.00	72.50	8.75	0.00	90.00	8.283	2	0.016

n = 34 per group; Min. = minimum; Max = maximum, GIM = Guided Imagery and Music; PITT = Psychodynamic Imaginative Trauma Therapy

The table shows significant improvement in symptom severity of structural dissociation over the course of therapy in both groups.

Wallner, Putnam, and Carlsson (1996) gave reference and cut-off scores for the DES-T of different clinical samples and a normal control group. Table 4.14 shows the pretest and posttest scores obtained from this study compared to the reference groups.

Table 4.14: Means for Scores on Dissociative Experience Scale Taxon Compared to Reference Groups

Group	Mean
Reference normal controls	0.71
Guided Imagery and Music posttest	6.43
Psychodynamic Imaginative Trauma Therapy posttest	13.20
Psychodynamic Imaginative Trauma Therapy pretest	17.66
Reference posttraumatic stress disorder	23.23
Control pretest	23.71
Cut-off dissociative disorder not otherwise specified	24.21
Guided Imagery and Music pretest	30.48
Control posttest	36.21
Cut-off dissociative identity disorder	41.51

The table shows that the pretest results of the PITT group and the control group are close to the reference results for people with posttraumatic stress disorder while the results from the pretest of the GIM group are above the cut-off for dissociative disorders, which for the DES-T is ≥ 25 (Wallner, Putnam & Carlsson, 1996). For the PITT group, the results at posttest are a bit lower than at pretest. For the GIM-group the results at posttest are much lower than any of the clinical reference groups. The results for the control group at posttest got well beyond the cut-off for dissociative disorders.

Percentages of participants above and below the cut-off score for dissociative disorders at pretest and posttest for each group are shown in Table 4.15.

Table 4.15: Percentages above Cut-Off Scores of the Dissociative Experience Scale Taxon

Group	Pretest		Posttest	
	% below	% above	% below	% above
	cut-off	cut-off	cut-off	cut-off
Guided Imagery and Music	29.4	70.6	91.2	8.8
Psychodynamic Imaginative	76.5	23.5	94.1	5.9
Trauma Therapy				
Control	64.7	35.3	32.4	67.6

$n = 34$ per group

The table shows that the symptoms of dissociation of most of the participants from the GIM and the PITT groups got below the cut-off score of 25 after 50 hours of therapy while the dissociative symptoms of some of the participants of the control group got above the cut-off score through waiting.

The second measurement instrument for dissociation used in this study is the shortened version of the Somatoform Dissociation Questionnaire (SDQ-5). The lowest possible score of the SDQ-5 is 5 meaning there are no symptoms of somatoform dissociation. The highest score is 25 indicating extremely severe symptoms of somatoform dissociation. For the SDQ-5, equality of variances in different samples was found. Means, standard deviations, pre-post correlations, and effect size are shown in Table 4.16.

Table 4.16: Means, Standard Deviations, Pre-Post Correlations, and Effect Size for Scores on the Somatoform Dissociation Questionnaire by Group

Group	Pretest		Posttest		Pre- Post <i>r</i>	Cohen's <i>d</i>	<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
Guided Imagery and Music	9.41	2.80	5.94	1.67	0.479	1.521	36.123	<
Psychodynamic Imaginative Trauma Therapy	9.03	3.66	9.65	5.30	0.508	-0.140		
Control	9.18	4.20	13.00	4.26	0.727	-1.222		

n = 34 per group

The table shows that the severity of somatoform dissociation in participants treated with GIM is reduced while the severity of symptoms worsened for the participants of the PITT and control groups. For the GIM and the PITT groups, Cohen's *d* was computed. In the table it can be seen that PITT has a small negative effect size while GIM has a very large positive effect size. Having to wait for therapy for at least nine months has a very large negative effect size.

A test of between-subjects effects shows a significant difference in severity of symptoms of somatoform dissociation among the three groups ($p < .001$). A post-hoc test was used to check where the results are significant. Tukey HSD shows that there were significant differences in change of severity of symptoms between the GIM and the control group ($p < .001$), between the PITT and the control group ($p = .001$), and between the GIM and the PITT group ($p < .001$). Only the symptomatology of the participants of the GIM group improved while the symptoms of the PITT group stayed more or less the same with a slight worsening and the symptoms of the control group worsened. The effect size of GIM vs. PITT is 1.14 which is a very large effect size.

For all three measurement points, Box's test was significant showing that there was a difference in the variances between the two groups receiving therapy. Arithmetic

transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.17.

Table 4.17: Medians and Ranges for Scores on the Somatoform Dissociation Questionnaire by Group

	Pretest			Mid-point			Posttest			X^2	<i>df</i>	<i>p</i>
	<i>m</i>	Min.	Max.	<i>m</i>	Min.	Max.	<i>m</i>	Min.	Max.			
GIM	9.00	6.00	16.00	7.00	5.00	13.00	5.50	5.00	12.00	54.183	2	< 0.001
PITT	8.00	5.00	18.00	8.00	5.00	15.00	7.00	5.00	22.00	0.486	2	0.784

n = 34 per group; Min. = minimum; Max = maximum, GIM = Guided Imagery and Music; PITT = Psychodynamic Imaginative Trauma Therapy

The table shows significant improvement in symptom severity of somatoform dissociation over the course of therapy in the GIM group but not in the PITT group.

The cut-off score of the SDQ-5 for any of the dissociative disorder listed in the DSM-IV is ≥ 8 (Nijenhuis, 2003). Percentages of participants above and below the cut-off score at pretest and posttest are shown in Table 4.18.

Table 4.18: Percentages above Cut-Off Scores of the Somatoform Dissociation Questionnaire

Group	Pretest		Posttest	
	% below	% above	% below	% above
	cut-off	cut-off	cut-off	cut-off
Guided Imagery and Music	29.4	70.6	94.1	5.9
Psychodynamic Imaginative Trauma Therapy	41.2	58.8	61.8	38.2
Control	50.0	50.0	11.8	88.2

n = 34 per group

The table shows that the symptoms of dissociation for most of the participants from the GIM-group (all except 2 participants) got below the cut-off score of 8 after 50 hours of therapy while the dissociative symptoms of some of the participants of the control group got above the cut-off score through waiting. For some participants from the PITT group the

symptoms of dissociation got below the cut-off score while for five participants (14.7 %) the symptoms of somatoform dissociation got more severe than they were before their therapy.

It can be seen that severity of symptoms of dissociation as measured with the DES-T and the SDQ-5 was significantly reduced in both the GIM and the PITT group compared to the control group. And severity of symptoms of dissociation was reduced significantly more for participants of the GIM group compared to participants of the PITT group. The effect size of GIM was very large as measured in both questionnaires while the effect size of PITT was small to medium when measured with the DES-T and small but negative when measured with the SDQ-5.

4.1.2.4 Effects on Interpersonal Problems: IIP-PD25

The Inventory of Interpersonal Problems for Personality Disorders (IIP-PD25) can be used for assessing interpersonal problems typical for persons with personality disorders, and for tracking symptom severity over the course of treatment. The scores of the IIP-PD25 range from 0-125. Before calculating outcome measures, homogeneity of variance in the three different samples was tested. Levene's test was significant showing that there was a difference in the variances among the three groups. Arithmetic transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.19.

Table 4.19: Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders by Group

	Pretest			Posttest			X^2	df	p
	m	Min.	Max.	m	Min.	Max.			
Guided Imagery and Music	36	10	76	7	0	36	65.447	2	<
Psychodynamic Imaginative Trauma Therapy	58.5	29	88	45	24	93			0.001
Control	40.5	18	64	55	35	86			

$n = 34$ per group; Min. = Minimum; Max = Maximum

The table shows that participants treated with GIM or PITT improved while the severity of problems worsened for the participants of the control group. A Kruskal-Wallis-Test shows that there was a significant difference in change of severity of problems between the groups ($p < .001$). Through Mann-Whitney Tests it could also be shown that there were significant differences in change of severity of problems between the GIM and the control group ($U = 4.00, p < .001$), between the PITT and the control group ($U = 133.50, p < .001$), and between the GIM and the PITT group ($U = 25.00, p < .001$). The symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group.

After looking at the IIP-PD25 as a whole, we now come to the five individual subscales. The first subscale measures interpersonal sensitivity. For this subscale, equality of variances in different samples was found. Means and standard deviations are shown in Table 4.20.

Table 4.20: Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Interpersonal Sensitivity” by Group

	Pretest		Posttest		<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Guided Imagery and Music	10.62	6.71	3.09	3.15	137.451	< .001
Psychodynamic Imaginative Trauma	13.96	4.32	12.56	3.80	(2,99)	
Therapy						
Control	11.62	4.65	15.91	3.32		

n = 34 per group

The table shows that participants treated with GIM or PITT improved while the severity of problems worsened for the participants of the control group. A test of between-subjects effects shows a significant difference in severity of problems with interpersonal sensitivity among the three groups ($p < .001$). A post-hoc test was used to check where the results are significant. Tukey HSD shows that there were significant differences in change of severity of symptoms between the GIM and the control group ($p < .001$), between the PITT and the control group ($p < .001$), and between the GIM and the PITT group ($p < .001$). The

symptoms of the participants of the GIM group improved significantly more than the symptoms of the participants of the PITT group.

The second subscale measures interpersonal ambivalence. Levene's test was significant showing that there was a difference in the variances among the three groups. Arithmetic transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.21.

Table 4.21: Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale "Interpersonal Ambivalence" by Group

	Pretest			Posttest			χ^2	df	p
	m	Min.	Max.	m	Min.	Max.			
Guided Imagery and Music	1	0	11	0	0	6	7.458	2	0.024
Psychodynamic Imaginative Trauma Therapy	6	0	15	4.5	1	15			
Control	3	0	16	6	0	17			

$n = 34$ per group; Min. = Minimum; Max = Maximum

The table shows that participants treated with GIM or PITT improved while the severity of symptoms worsened for the participants of the control group. A Kruskal-Wallis-Test shows that there was a significant difference in change of severity of problems with interpersonal ambivalence between the groups ($p = .024$). Through Mann-Whitney Tests it could also be shown that there were significant differences in change of severity of problems between the GIM and the control group ($U = 339.50$, $p = .003$), but not between the PITT and the control group ($U = 475.00$, $p = .205$) or the GIM and the PITT group ($U = 496.50$, $p = .312$).

The third subscale measures aggression. Levene's test was significant showing that there was a difference in the variances among the three groups. Arithmetic transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.22.

Table 4.22: Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Aggression” by Group

	Pretest			Posttest			X^2	df	p
	m	Min.	Max.	m	Min.	Max.			
Guided Imagery and Music	0	0	20	0	0	2	21.488	2	<
Psychodynamic Imaginative	7	0	20	7	0	20			0.001
Trauma Therapy									
Control	2	0	17	4	0	20			

$n = 34$ per group; Min. = Minimum; Max = Maximum

A Kruskal-Wallis-Test shows that there was a significant difference in change of severity of problems with aggression between the groups ($p < .001$). Through Mann-Whitney Tests it could also be shown that there were significant differences in change of severity of problems between the GIM and the control group ($U = 223.00$, $p < .001$), and between the GIM and the PITT group ($U = 340.00$, $p = .003$). The differences in change of severity of problems with aggression between the PITT and the control group is approaching significance ($U = 427.50$, $p = .063$)

The fourth subscale measures need for social approval. For this subscale, equality of variances in different samples was found. Medians and ranges are shown in Table 4.23.

Table 4.23: Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Need for Social Approval” by Group

	Pretest		Posttest		F	p
	M	SD	M	SD		
Guided Imagery and Music	8.79	6.02	2.44	2.63	48.867	< 0.001
Psychodynamic Imaginative	17.68	3.01	13.09	3.67	(2,99)	
Trauma Therapy						
Control	11.44	4.94	12.85	5.59		

$n = 34$ per group

The table shows that participants treated with GIM or PITT improved while the severity of problems worsened for the participants of the control group. A test of between-subjects effects shows a significant difference in severity of problems with interpersonal sensitivity among the three groups ($p < .001$). A post-hoc test was used to check where the results are significant. Tukey HSD shows that there were significant differences in change of severity of problems with aggression between the GIM and the control group ($p < .001$), and between the PITT and the control group ($p < .001$). The change in severity of problems with aggression between the GIM and the PITT group is not significant ($p = .251$).

The fifth subscale measures lack of sociability. Levene's test was significant showing that there was a difference in the variances among the three groups. Arithmetic transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.24.

Table 4.24: Medians and Ranges for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale "Lack of Sociability" by Group

	Pretest			Posttest			X^2	df	p
	m	Min.	Max.	m	Min.	Max.			
Guided Imagery and Music	9.5	0	16	1	0	10	73.671	2	<
Psychodynamic Imaginative	12	7	18	8	2	19			0.001
Trauma Therapy									
Control	3	0	20	12	2	20			

$n = 34$ per group; Min. = Minimum; Max = Maximum

The table shows that participants treated with GIM or PITT improved while the severity of symptoms worsened for the participants of the control group. A Kruskal-Wallis-Test shows that there was a significant difference in change of severity of problems with lack of sociability between the groups ($p < .001$). Through Mann-Whitney Tests it could also be shown that there were significant differences in change of severity of problems between the GIM and the control group ($U = 223.00$, $p < .001$), between the PITT and the control group ($U = 158.00$, $p < .001$), and between the GIM and the PITT group ($U = 354.00$, $p = .006$).

It can be seen that for the whole IIP-PD25 and most of the subscales, severity of interpersonal problems was significantly reduced in both the GIM and the PITT group compared to the control group. Severity of interpersonal problems was reduced significantly more for participants of the GIM group compared to participants of the PITT group. In the subscales of interpersonal ambivalence and of aggression, PITT did not show significant results. In the subscale of need for social approval, GIM and PITT were doing equally well with no significant differences in change of severity of problems between the two groups.

4.1.2.5 Effects on Sense of Coherence: SOC-13

The SOC-13 measures factors that promote improvement of health. The lowest possible score of the SOC-13 is 13, meaning that the participant has almost no sense of coherence and therefore no resources that promote improvement of health. The highest possible score is 91, meaning that the participant has a very strong sense of coherence and excellent resources that promote improvement of health. For the SOC-13, equality of variances in different samples was found. Means, standard deviations, pre-post correlations, and effect size are shown in Table 4.25.

Table 4.25: Means, Standard Deviations, Pre-Post Correlations, and Effect Size for Scores on the Sense of Coherence Scale by Group

Group	Pretest		Posttest		Pre- Post <i>R</i>	Cohen's <i>d</i>	<i>F</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
Guided Imagery and Music	43.29	6.84	70.62	9.09	0.275	2.850	133.670 (2,99)	< .001
Psychodynamic Imaginative Trauma Therapy	45.03	12.17	52.68	14.55	0.595	0.636		
Control	53.53	12.52	34.79	9.31	0.488	-1.697		

n = 34 per group

The table shows that sense of coherence in participants treated with GIM or PITT is enhanced while sense of coherence was reduced through waiting for therapy in the participants of the control group. For the GIM and the PITT groups, Cohen's d was computed. In the table it can be seen that PITT has a medium effect size while GIM has a very large effect size. Having to wait for therapy for at least nine months has a very large negative effect size.

A test of between-subjects effects shows a significant difference in sense of coherence among the three groups ($p < .001$). A post-hoc test was used to check where the results are significant. Tukey HSD shows that there were significant differences in change of sense of coherence between the GIM and the control group ($p < .001$), between the PITT and the control group ($p < .001$), and between the GIM and the PITT group ($p < .001$). Sense of coherence of the participants of the GIM group improved significantly more than sense of coherence of the participants of the PITT group. The effect size of GIM vs. PITT is 1.80 which is a very large effect size.

For all three measurement points, Box's test was significant showing that there was a difference in the variances between the two groups receiving therapy. Arithmetic transformation of the data could not solve this problem; therefore, nonparametric statistics were used. Medians and ranges are shown in Table 4.26.

Table 4.26: Medians and Ranges for Scores on the Sense of Coherence Scale by Group

	Pretest			Mid-point			Posttest			χ^2	df	p
	m	Min.	Max.	m	Min.	Max.	m	Min.	Max.			
GIM	43.0	29.0	55.0	58.0	42.0	77.0	74.0	56.0	84.0	62.571	2	< 0.001
PITT	44.0	27.0	65.0	50.0	28.0	66.0	55.5	19.0	73.0	6.713	2	0.035

$n = 34$ per group; Min. = minimum; Max = maximum, GIM = Guided Imagery and Music; PITT = Psychodynamic Imaginative Trauma Therapy

The table shows significant improvement in sense of coherence over the course of therapy in both groups.

Schumacher and Brähler (2000) found mean SOC-13 scores of 64.52 ($N = 384$) for German women who are 18-40 years old, and of 64.42 ($N = 360$) for women who are 41-60 years old. They used a non-clinical sample. The mean SOC-13 scores in all three groups were below average at pretest. Only the mean SOC-13 score of the GIM-group improved above average at posttest. Table 4.27 shows how many percent of participants per group were above or below average at pretest and at posttest.

Table 4.27: Percentages of Participants below and above Average of Scores on the Sense of Coherence Scale

Group	Pretest		Posttest	
	% below average	% above average	% below average	% above average
Guided Imagery and Music	100	0	26.5	73.5
Psychodynamic Imaginative Trauma Therapy	85.3	14.7	85.3	14.7
Control	76.5	23.5	100	0

The table shows that in the GIM group the SOC-13 scores of 73.5 % of the women went from below average to above average after 50 hours of therapy; for the PITT group, there was no change, and the women of the control group who were still above average before their waiting time got below average after waiting.

Schumacher and Brähler (2000) give also percentage ranks for SOC-13 scores. In Table 4.28 the mean SOC-13 scores of each group at pretest and posttest from this study are compared to the percentage of women (non-clinical sample) in Schumacher and Brähler's (2000) study ($N = 744$) who were below that score.

Table 4.28: Mean Scores on the Sense of Coherence Scale per Group Compared to Percentage of Women in Schumacher and Brähler's Study below that Mean Score

Group	Pretest		Posttest	
	<i>M</i>	% below in Schumacher & Brähler	<i>M</i>	% below in Schumacher & Brähler
Guided Imagery and Music	43.29	< 5	70.62	70
Psychodynamic Imagina- tive Trauma Therapy	45.03	5	52.68	15
Control	53.53	15	34.79	< 5

The table shows that participants from the GIM group showed SOC-13 scores well above average German women at posttest while mean scores in all groups at pretest and in the control and PITT groups at posttest were well below average German women. This might indicate that through GIM women with Complex PTSD might find new resources and strengthen existing resources that promote health. This again might indicate that the outcome reached through GIM therapy would be stable over time. The next section will give further evidence for this.

4.1.3 Long-term Effects of GIM Treatment

This section shows the long-term effects of GIM treatment. For that, the posttest data from the GIM treatment group is compared with data from a separate follow-up group. The participants from the follow-up group had a mean of 165 hours of therapy, and they had finished their therapies at least 12 months before filling out the questionnaires. The mean number of years between the end of their therapies and their taking part in the study is 4 years.

Before data analysis is conducted, the data is controlled for matching of the two groups which might lead to covariates. Then the data of the five questionnaires is presented.

4.1.3.1 Matching of Groups and Covariates

In this section, the steps are described that were taken before analyzing the data. These were checking where groups match and where they do not match, and checking if any of the areas the groups do not match are covariates.

The GIM treatment group and the GIM follow-up group match in the following areas:

- Nationality of the participants
- Academic degree
- Perpetrator contact during therapy

Both groups are international groups of participants. Table 4.29 shows the distribution of nationalities.

Table 4.29: Distribution of Participants' Nationalities per Group

Nationality	Treatment group	Follow-up group	χ^2	df	p
German	8	13	6.962	5	0.223
Swedish	5	1			
Turkish		1			
Croatian	1				
US American	20	18			
Danish		1			

Also perpetrator contact in these two groups is matching as is shown in Table 4.30.

Table 4.30: Perpetrator Contact

	Perpetrator contact		χ^2	df	p
	yes	no			
Treatment	18	16	0,971	1	0.230
Follow-up	22	12			

The table shows that in both groups there were more participants having perpetrator contact than participants not having perpetrator contact during their therapies.

The groups did not match in the area of preference for the gender of the therapist. However, in both groups the gender of the therapist was either the preferred gender of the participant or the gender of the therapist did not matter for the participant. The difference between these two categories has no effect on therapy.

In the area of marital status the two groups are not significantly different, but the difference approaches significance. The distribution of marital status is shown in Table 4.31.

Table 4.31: Marital Status

	Marital Status		χ^2	df	p
	Married or living with a partner	Not married and not living with a partner			
Treatment	14	20	3.386	1	0.066
Follow-up	21	12			

It should be noted, however, that the participants of the GIM treatment group reported their marital status at the time before they started therapy, while the participants of the follow-up group reported their marital status at the time they filled out the questionnaire which is at least one year after having finished their therapies. It is not known how many participants of the follow-up group married or moved together with a partner during or after their therapy.

To check whether any of the areas in which the groups did not match (significantly or approaching significance) is a covariate, correlations between these variables and the posttest scores were computed. No significant correlations were found between therapy outcome and any of the variables. No covariates were used in the following calculations.

4.1.3.2 Effects on Symptoms of Complex PTSD: SIDES-SR

The Self-report Inventory for Disorder of Extreme Stress (SIDES-SR) is the main measurement instrument in this study. For calculating outcome, symptom severity scoring was used: The total score of the questionnaire was taken and divided by the number of items. For the SIDES-SR, equality of variances in the two samples was found. Means and standard deviations are shown in Table 4.32.

Table 4.32: Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	0.36	0.21	4.74 (1,66)	0.033
Follow-up	0.24	0.16		

n = 34 per group

The table shows that symptoms of Complex PTSD as measured with the SIDES-SR were significantly lower for the follow-up group than for the treatment group after 50 hours of therapy. This might indicate that more therapy could help to further alleviate the symptoms of Complex PTSD, and that the results are stable over time after finishing therapy or that improvement continues after therapy has ended.

After looking at the SIDES-SR as a whole, we now come to the six individual subscales. The first subscale measures alterations in regulation of affect and impulses. Homogeneity of variance in the two different samples was tested. Levene's test was significant showing that there is a difference between the variances in the population. Reciprocal transformation of the data was used to solve the problem. Means and standard deviations are shown in Table 4.33.

Table 4.33: Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale "Regulation of Affect and Impulses" by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	0.32	0.33	0.676 (1,66)	0.414
Follow-up	0.25	0.23		

n = 34 per group

The table shows that symptoms of alterations in regulation of affects and impulses are scored lower at follow-up than after 50 hours of therapy, but the reduction is not significant. This might indicate that the results are stable over time after finishing therapy.

The second subscale measures amnesia and dissociation. For this subscale, equality of variances in the two samples was found. Means and standard deviations are shown in Table 4.34.

Table 4.34: Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Amnesia and Dissociation” by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	0.56	0.44	7.101 (1,66)	0.010
Follow-up	0.33	0.27		

n = 34 per group

The table shows that symptoms of amnesia and dissociation as measured with the SIDES-SR were significantly lower for the follow-up group than for the treatment group after 50 hours of therapy. This might indicate that more therapy could help to further alleviate the symptoms of amnesia and dissociation, and that the results are stable over time after finishing therapy.

The third subscale measures alterations in self-perception. For this subscale, equality of variances in the two samples was found. Means and standard deviations are shown in Table 4.35.

Table 4.35: Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Alterations in Self-Perception” by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	0.28	0.29	.738 (1,66)	0.394
Follow-up	0.22	0.32		

n = 34 per group

The table shows that symptoms of alterations in self-perception are scored lower at follow-up than after 50 hours of therapy, but the reduction is not significant. This might indicate that the results are stable over time after finishing therapy.

The fourth subscale measures alterations in relations with others. For this subscale, equality of variances in the two samples was found. Means and standard deviations are shown in Table 4.36.

Table 4.36: Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Alterations in Relations with Others” by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	0.45	0.29	3.239 (1,66)	0.076
Follow-up	0.32	0.28		

n = 34 per group

The table shows that symptoms of alterations in self-perception are scored lower at follow-up than after 50 hours of therapy. The reduction is approaching significance. This might indicate that more therapy could help to further alleviate the symptoms of alterations in relations with others, and that the results are stable over time after finishing therapy.

The fifth subscale measures somatization. Also here, homogeneity of variance in the two different samples was tested. Levene’s test was significant showing that there is a difference between the variances in the population. Reciprocal transformation of the data was used to solve the problem. Means and standard deviations are shown in Table 4.37.

Table 4.37: Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Somatization” by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	0.22	0.27	1.274 (1,66)	0.263
Follow-up	0.15	0.14		

n = 34 per group

The table shows that symptoms of somatization are scored lower at follow-up than after 50 hours of therapy, but the reduction is not significant. This might indicate that the results are stable over time after finishing therapy.

The sixth subscale measures disruptions in systems of meaning. For this subscale, equality of variances in the different samples was found. Means and standard deviations are shown in Table 4.38.

Table 4.38: Means and Standard Deviations for Scores on the Self-Report Inventory for Disorder of Extreme Stress Subscale “Disruptions in Systems of Meaning” by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	0.21	0.23	2.408 (1,66)	0.125
Follow-up	0.12	0.20		

n = 34 per group

The table shows that symptoms of disruption in systems of meaning are scored lower at follow-up than after 50 hours of therapy, but the reduction is not significant. This might indicate that the results are stable over time after finishing therapy.

It can be seen that for the whole SIDES-SR and the subscale of amnesia and dissociation, severity of symptoms of Complex PTSD was significantly lower in the follow-up group than in the treatment group after 50 therapy hours. For all other subscales severity of symptoms was lower at follow-up than after 50 therapy hours, but not significantly lower. This might indicate that more therapy could help to further alleviate the symptoms of Complex PTSD, and that the results are stable over time after finishing therapy.

4.1.3.3 Effects on Dissociation: DES-T and SDQ-5

Two instruments were used to measure dissociation: the Dissociative Experiences Scale Taxon (DES-T) measuring structural dissociation, and the Somatoform Dissociation Questionnaire in its short version (SDQ-5) looking at dissociative phenomena in the body. First the results of the DES-T, and then the results of the SDQ-5 are presented.

The lowest possible score of the DES-T is zero, meaning that at no time the participant is experiencing dissociative symptoms. The highest possible score is 100, meaning that the participant is experiencing all the dissociative symptoms mentioned in the questionnaire all the time. For the DES-T, homogeneity of variance in the two different samples was tested. Levene’s test was significant showing that there is a difference

between the variances in the population. Logarithmic transformation of the data was used to solve the problem. Means and standard deviations are shown in Table 4.39.

Table 4.39: Means and Standard Deviations for Scores on the Dissociative Experiencing Scale Taxon by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	6.43	8.16	2.247 (1,66)	0.139
Follow-up	4.23	3.55		

n = 34 per group

The table shows that severity of symptoms of structural dissociation are scored lower at follow-up than after 50 hours of therapy, but the reduction is not significant. This might indicate that the results are stable over time after finishing therapy.

The second measurement instrument for dissociation used in this study is the shortened version of the Somatoform Dissociation Questionnaire (SDQ-5). The lowest possible score of the SDQ-5 is 5 meaning there are no symptoms of somatoform dissociation. The highest score is 25 indicating extremely severe symptoms of somatoform dissociation. For the SDQ-5, equality of variances in the different samples was found. Means and standard deviations are shown in Table 4.40.

Table 4.40: Means and Standard Deviations for Scores on the Somatoform Dissociation Questionnaire by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	5.94	1.67	2.293 (1,66)	0.135
Follow-up	5.47	0.71		

n = 34 per group

The table shows that severity of symptoms of somatoform dissociation are scored lower at follow-up than after 50 hours of therapy, but the reduction is not significant. This might indicate that the results are stable over time after finishing therapy.

The results of both questionnaires might indicate that the results of GIM therapy in the area of dissociation are stable over time after finishing therapy.

4.1.3.4 Effects on Interpersonal Problems: IIP-PD25

The Inventory of Interpersonal Problems for Personality Disorders (IIP-PD25) can be used for assessing interpersonal problems typical for persons with personality disorders, and for tracking symptom severity over the course of treatment. The scores of the IIP-PD25 range from 0-125.

For the IIP-PD25, equality of variances in the different samples was found. Means and standard deviations are shown in Table 4.41.

Table 4.41: Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	8.47	6.21	0.40 (1,66)	0.529
Follow-up	9.74	9.87		

n = 34 per group

The table shows that severity of interpersonal problems is scored higher at follow-up than after 50 hours of therapy, but not significantly higher. This might indicate that the results are stable over time after finishing therapy.

After looking at the whole questionnaire, we can look at the five subscales. The first subscale measures interpersonal sensitivity. For this subscale, equality of variances in the different samples was found. Means and standard deviations are shown in Table 4.42.

Table 4.42: Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Interpersonal Sensitivity” by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	3.09	3.15	0.355 (1,66)	0.553
Follow-up	3.56	3.36		

n = 34 per group

The table shows that severity of problems with interpersonal sensitivity is scored higher at follow-up than after 50 hours of therapy, but not significantly higher. This might indicate that the results are stable over time after finishing therapy.

The second subscale measures interpersonal ambivalence. For this subscale, equality of variances in the different samples was found. Means and standard deviations are shown in Table 4.43.

Table 4.43: Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Interpersonal Ambivalence” by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	0.94	1.69	0.155 (1,66)	0.695
Follow-up	1.15	2.54		

n = 34 per group

The table shows that severity of problems with interpersonal ambivalence is scored higher at follow-up than after 50 hours of therapy, but not significantly higher. This might indicate that the results are stable over time after finishing therapy.

The third subscale measures aggression. Levene’s test was significant showing that there is a difference between the variances in the population. Arithmetic transformation of the data could not solve the problem, therefore nonparametric statistics were used. Means and standard deviations are shown in Table 4.44.

Table 4.44: Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Aggression” by Group – Long-Term Effects

Group	<i>m</i>	Minimum	Maximum	<i>p</i>
Treatment	0	0	2	0.198
Follow-up	0	0	7	

n = 34 per group

The table shows that there was no significant difference in severity of aggression between the two groups. This might indicate that the results are stable over time after finishing therapy.

The fourth subscale measures need for social approval. For this subscale, equality of variances in the different samples was found. Means and standard deviations are shown in Table 4.45.

Table 4.45: Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Need for Social Approval” by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	.45	.29	3.239 (1,66)	0.076
Follow-up	.32	.28		

n = 34 per group

The table shows that problems with need for social approval are scored lower at follow-up than after 50 hours of therapy. The reduction is approaching significance. This indicates that more therapy could help to further alleviate the problems with need for social approval, and that the results are stable over time after finishing therapy.

The fifth subscale measures lack of sociability. For this subscale, equality of variances in the different samples was found. Means and standard deviations are shown in Table 4.46.

Table 4.46: Means and Standard Deviations for Scores on the Inventory of Interpersonal Problems for Personality Disorders Subscale “Lack of Sociability” by Group – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	1.82	2.29	0.836 (1,66)	0.364
Follow-up	1.29	2.48		

n = 34 per group

The table shows that severity of problems with lack of sociability are scored lower at follow-up than after 50 hours of therapy, but not significantly lower. This might indicate that the results are stable over time after finishing therapy.

The results of the IIP-PD25 and its subscales might indicate that the outcome of GIM therapy in the area of interpersonal problems is stable over time after finishing therapy.

4.1.3.5 Effects on Sense of Coherence: SOC-13

The SOC-13 measures factors that promote improvement of health. The lowest possible score of the SOC-13 is 13, meaning that the participant has almost no sense of

coherence and no resources that promote improvement of health. The highest possible score is 91, meaning that the participant has a very strong sense of coherence and excellent resources that promote improvement of health. For the SOC-13, equality of variances in the two samples was found. Means and standard deviations are shown in Table 4.47.

Table 4.47: Means and Standard Deviations for Scores on the Sense of Coherence Scale – Long-Term Effects

Group	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>
Treatment	70.62	9.09	0.809 (1,66)	0.372
Follow-up	72.68	9.77		

n = 34 per group

The table shows that sense of coherence is scored higher at follow-up than after 50 hours of therapy, but not significantly higher. This might indicate that the results are stable over time after finishing therapy.

4.1.4 Summary of Results

In summary, the results revealed greater improvement in symptoms of Complex PTSD and dissociation, as well as greater reduction of interpersonal problems and greater improvement in quality of life for both the GIM treatment group and the PITT group as compared to the control group. In addition participants from the GIM follow-up group had similar scores as the GIM treatment group at posttest in the areas of dissociation, interpersonal problems, and quality of life. This suggests that results in these areas may be stable over time. Symptoms of Complex PTSD are lower in the GIM follow-up group than in the GIM treatment group at posttest. This suggests that more treatment than 50 therapy hours could further reduce symptoms of Complex PTSD, and this reduction, too, might be stable over time after termination of therapy. Therefore, all hypotheses formulated in 3.2.4 were confirmed. Both GIM and PITT are indicated for severely traumatized women.

The results in addition revealed greater improvement in symptoms of Complex PTSD and dissociation, as well as greater reduction of interpersonal problems and greater improvement in quality of life for participants of the GIM treatment group as compared to the PITT group. Effect size could be measured for the two dissociation scales, and for the SOC. The effect size for GIM when comparing pretest to posttest, was very large on all measurements, while the effect size of PITT was small to medium for the DES-T and the SOC. On the SDQ-5, PITT had a small negative effect size. This suggests that treatment with GIM and its modification may be superior to treatment with PITT for severely traumatized women in all areas measured in this study.

4.2 Results of the Qualitative Investigation

4.2.1 Introduction

I embarked on the qualitative part of the research by first reflecting on my own GIM therapy and other kinds of psychotherapy before I interviewed other research participants. The areas I focused on were the roles of music, the roles of imagery, the roles of the therapeutic relationship, and general aspects of trauma therapy. My goal for that is to address research questions 1, 3, and 4 of this study:

Research question 1:

When would GIM and when would PITT be indicated?

Research question 3:

What are different roles of music in imagery-based trauma therapy?

a) What could music be particularly helpful with?

b) Are there limitations in the use of music?

Research question 4:

What are characteristics of the treatment of patients with Complex PTSD?

Research question 1 is in part already answered through the quantitative part of this study.

However, not only therapy outcome guides the search for a suitable trauma therapy

method, but also personal likes and dislikes, as well as individual qualities and experiences that cannot be seen in quantitative outcome.

This section starts with my own reflections on my therapy process which stem from the time before I conducted any interviews. The next part is the results from the interviews, followed by two exemplary individual depictions, one from a research participant treated with GIM, and one treated with PITT. The section is finished with a creative synthesis.

4.2.2 Reflections on my Personal Therapy Process

Before I conducted any of the interviews with research participants, I delved into my own experiences with music, imagery, and the therapeutic relationship in my GIM therapy. I reflected on my personal experiences first for three reasons:

1. I wanted to have a clear and uninfluenced understanding of my experience before I heard about other women's experiences.
2. I wanted to use my experience to help create an interview-guideline for the interviews with the other research participants.
3. I wanted to make as much of my tacit knowledge and unconscious or preconscious assumptions about the roles of music, imagery, and the therapeutic relationship conscious before going into the interviews, so that I could keep as open as possible for the other research participants' experiences.

In the process of collecting data, my knowledge about the three areas was expanded through experiences by others which were different than my own experience or which brought still more tacit knowledge of my own into consciousness as they named things that I had experienced, too. In this first part, I will summarize my reflections on music, imagery, and the therapeutic relationship from the time before I interviewed any of the other research participants.

4.2.2.1 Music

In the GIM literature, one can find several references to the function of music in GIM therapy (see 2.3.4), however, very little is said about the meaning of music in GIM for the individual client. Only Isenberg-Grzeda (1999) wrote about her experience from the client-perspective. For a summary see 2.3.4. As music in GIM offers the possibility to be used as a self-object, I expected the biggest differences between the roles of music (compared to the roles of imagery and the therapeutic relationship) from the therapist's and from the client's perspectives. I also had the most difficulties bringing my subjective meanings into consciousness and into explicit language with the category of music. I only knew for sure that music was important for me – but how? And for what? To get a better understanding of it, I used Re-imaging as explained in 3.3.2 to complete my knowledge which I got from reflecting on the topic.

For this, I used examples from four personal GIM sessions which were meaningful to me. They took place with two different therapists from 2001 – 2005. Three of the sessions were pivotal, opening new doors for me. They were all conducted by one therapist. The first session (by another therapist) showed me that I needed to change therapists as that therapist had become abusive towards me. It was a very difficult session because music and imagery brought several insights to consciousness which I could not share with my therapist as I was afraid of his aggression towards me. It was clear that his boundary violations could not have been reflected in the therapy with him. I remember him asking me about the meaning of my imagery from that session and how it connected to my life. I kept saying “I don't know”, while in reality, of course, I knew. Here is a brief overview of the sessions I used and the music:

1. Leaving an abusive therapist: The Keeper of Strength
 - Time: January 2001
 - Therapist A

- Music¹¹: The Last of Mohicans, Main Title & Massacre-Canoes; The Mission, Remorse & On Earth as it is in Heaven
2. Stabilization: Teaching Relationships
 - Time: Summer 2001
 - Therapist B
 - Music: Bach, Concerto for 2 Violins, Largo
 3. Working through Traumas: Mothering
 - Time: September 2002
 - Therapist B
 - Music: Pärt, Spiegel im Spiegel
 4. Integration: Holding Knowledge of Intimate Relationships
 - Time: September 2005
 - Therapist B
 - Music: Satie, Gymnopedie # 2 (orchestral arrangement)

From the Re-imaging¹² and my reflections before and after it, I found the following categories of meaning of music in my own GIM therapy:

1. Music as teacher, as keeper of knowledge or abilities
2. Music as relationships
3. Music as space
4. Music as representative of dissociated parts
5. Music as keeper

In the following I will further explain these categories.

Music as Teacher, and as Keeper of Knowledge or Abilities

In the first selected session, music taught me to fight and to protect, flight, not to be submissive, and to speak the truth. Especially the second piece with its strong and persis-

¹¹ The music was chosen by my therapist, only the music for this first selected session was chosen by me. If the therapist would have chosen that piece, most probably it would have been very overwhelming and destructive for me at that time.

¹² For a description see 3.3.2.

tent rhythm can model fight and flight. The music is strong and mainly rather loud. It does not succumb but stands its ground. The dynamically softer parts of the first and third piece are not weak at all, but rather paint underlying tension that is waiting to burst (first piece) or jump (third piece) out. The music is not afraid of showing itself as it is, even though it has to fight for it. In the Re-imagining, I being the music said:

I extend and move out to move him [therapist A] away. I am standing firmly on the ground and lift her up. She cannot stay here. It is too dangerous. I am standing on the ground for her. I am clearly speaking the truth. He cannot move me away or silence me. I am taking her away from this place into safety. We have to leave immediately. We have to run to prevent her from more danger. I am big and strong and beautiful. He will never win.

My main way of dealing with new traumas or attacks from the outside was to freeze. The music showed me different ways of dealing with it, which finally helped me to leave this therapist.

In the second session, music was teaching me how to relate and be in relationship. The two violins are equal. There is not one trying to dominate the other like in abusive relationships. The instruments teach how to speak with each other and how to stay connected. In the Re-imagining, I as the music said:

We [the instruments and voices] are speaking the same thing. It is possible that two instruments speak the same thing and keep their identities. There is a bit of tension and resolution. There are different points of view, ideas, living together in the same music. It is possible to speak about mistakes and strengths.

The music of the third selected session was teaching me mothering and caring for wounded parts. It models how to breathe and how to make gentle movements. This very gentle piece of music has a slow, relaxing tempo. It is in no way overwhelming, so it can even be with a very small, traumatized child. The music models how to regulate the very basic bodily functions like the mother models them for her baby.

The music of the last selected session was teaching me about love-relationships, an area of life I usually was shying away from. Due to early interpersonal and transgenerational traumatizations, I neither was able to develop a felt knowledge of intimate relationships, nor did I have good models. The music holds knowledge that is needed, information that is there at an archetypal level. The music is airy. It gives space and still provides some holding. There is a rather big ambitus, but enough structure.

Music as Relationships

Music is offering different kinds of relationships. The relationships can be seen between the different voices, between different instruments, between different components (i.e. between rhythm and melody etc.), or between groups of these. Both client and therapist are also invited to go into relationship with the music. In the first session, the music suggested relationships in battle to me. Battle is depicted in the music, but I also placed the music between my therapist and me as a form of protection (from the Re-imaging: "I am the music. I am standing between [therapist A] and her. I am standing strong and grounded. I am big and beautiful. You [therapist A] can look at me but you cannot touch me or make contact with me."). I used the aggression in the music to fight the aggression of the therapist towards me, and also to protect me from his aggression. The music cut the contact to the therapist, so that finally I could leave him.

After I had left this abusive therapist, I started therapy with therapist B. Due to early abuse and the new traumatization through therapist A, being in therapy was quite difficult for me. Can I trust this new therapist? Will he abuse me, too? How can I be in relationship with him in a way that therapy works? These were all questions I was struggling with at the time of the second session. The two violins are in a good relationship with each other. They are clear and honest. The violins are also supported by the orchestra which resembles the therapist, the structure of therapy, or the ethical background of the therapist supporting the client in the therapeutic relationship. This is what is needed between thera-

pist and client, especially if the client had experienced abusive therapeutic relationships in the past.

The music of the third session is like the relationship a mother offers to a small child, or a helper offers to a wounded person, or an inner adult part offers to a wounded inner child part. In the Re-imaging I put it like this:

I am the music. I have hands, gently touching, very careful. I hold her in my arms.
... It feels like holding a child, a very small child that was hurt. She cannot speak yet or walk. She has a lot of wounds. I am putting a blanket around her to keep her warm.

In the fourth session, the music was like a love-relationship to me. The original imagery was a couple dancing on a glade in the moonlight. The melody is romantic, longing, and gentle. It is played and created by different instruments similar to two partners creating a dance, their relationship, their shared life-space

Music as Space

Music to me offered a (potential) space for myself and my imagery. Different kinds of music were also different kind of spaces or places, and the spaces have different functions. In the first session, the music was keeping space between “war parties”. It was also a space for protection and fight.

The music of the second session offered a space for trying out relationships, for tension and release, and for being close but not merging. The music was also clearing the space from abuse to make attachment and a positive therapeutic relationship possible. It is clear as a therapeutic relationship should be, especially in trauma therapy.

The music of the third session provided space for the wounded part, for hurts, and for healing. During the fourth session, the music offered space for dancing, for being together. This airy music has enough space to breathe for both partners. In the Re-imaging I said being the music: “I am the space where the couples breathe, the space in between [them]. It is possible to breathe and have both distance and closeness.”

Music as Representative of Dissociated Parts

Music for me could represent dissociated parts of myself, some of them were more ego-syntonic, and others were quite split off and rather ego-dystonic. Music offered me possibilities to

1. develop imagery that represented these dissociated parts;
2. contact and interact with these parts of myself; and
3. identify with these parts and by that bring them more into daily life and – if necessary – allow them to become more ego-syntonic.

The music of the first session represented a fight-part of me. Anger and fighting for me had a negative connotation because in my life I often became the victim of traumatic rage by a number of perpetrators. With this fight-part, I had split off much of my strength. However, in the situation I was – namely faced with abuse by my therapist – I needed all my strength to fight his aggression and to get away from him. The music allowed me to access this part of myself. In the original imagery, I was a pregnant Polynesian priestess from many centuries ago. She was attacked by some people, one of them being the father of her child. I wrote about the original imagery: “The music is the war, the leaving, the rest of my strength, my inner strength, the drama of the situation, my inner knowing that I and my child will survive.”

Being in the struggle with my former therapist and the training institute I was assisting, I started therapy with a new therapist (B). While in my everyday life the fighting and ongoing traumatizations were not over, in my new therapy I needed a different kind of communication. The music of the second session represented the “normal”, peaceful conversation and with that an “apparently normal” part (for the definition of that, see 2.1.3). This was an ego-syntonic part, and easier to identify with than the fight-part.

In the third session, the music represented a number of inner parts: wounded children and a caring mother, all ego-syntonic. I could easily identify with them and allow the necessary healing to take place, both during the session and after that in everyday life.

The most ego-dystonic part was that of the lover brought through the music of the fourth session. In the original imagery this could be seen as I was not able yet to be one of the two partners dancing on the glade, but I was just watching them from a distance. The whole scene also had a mystical quality (night, moonlight), not an everyday-quality which would be more natural for partnership-issues. In the imagery, however, there also was the wish to identify more with the music and with the woman of the couple: “I want to learn how to dance like that.” In my life till then, I had experienced and witnessed partnership rather as a source of danger, humiliation, aggression, and traumatization, than as a source of love, support, and compassion. It was interesting that I had this session shortly before meeting my current partner for the first time. The music was a timely choice of my therapist, and a clear reflection of an inner part that wanted to come more to the forefront in my life.

Music as Keeper

Music for me could keep the energy of something that I could not live (yet). This quality only appeared in the first two sessions. In the music of the first session, music kept my strength in times of extreme suppression by my therapist (A) and the training institute I was assisting for at that time. My feeling was that they wanted to take as much of my strength away, so that they could keep up their unethical behavior without me questioning it. The music was a safe place to store it – and to retrieve it later or whenever necessary during that very difficult time.

The music of the second session kept the therapeutic relationship and – in a way – also my new therapist (B). When I had the session, I still had perpetrator contact with ongoing abuse. I would have needed weekly therapy sessions, but as my therapist was practicing too far away, this was not possible. I used the Bach as transitional object between the sessions to keep the therapy, the therapeutic relationship, and the transference-process alive, and “to have my therapist closer” between sessions.

At this place I would like to compare my categories to those mentioned by Isenberg-Grzeda (1999). By looking from a client-perspective at the roles of music in her own sessions, she broadly offers five categories:

1. The structure of the music gives structure to inner chaos of the client.
2. The music elicits direct physical responses in the client.
3. Music as holding and enveloping the client; blissful fusion with the music while the therapist recedes into the background.
4. Music as threatening or overwhelming. The client fights with the music, flees from it or succumbs to it.
5. The client is filled with the energy of the music

The first two of Isenberg-Grzeda's categories could be seen in my sessions as well. The structuring aspect of music can be seen in my categories of music as teacher and music as keeper. I consider this structuring quality as essential for trauma-therapy. The eliciting of direct physical response could be seen in the third session, where music elicited a direct physical response of breathing and activated the social engagement system involving the ventral vagal system during hypoarousal. This quality of music can be both helpful and hindering in trauma-therapy. In my third session, it was clearly helpful. On the other hand it could be hindering where music might trigger flashbacks with the physical reactions of the original trauma.

Music as holding, Isenberg-Grzeda's third category, is experienced in the third and fourth session, but in my experiences differentiation was more important than fusion. Experiences of being threatened or overwhelmed by the music can happen in trauma-therapy, and also happened to me in my very early sessions. I did not choose any of those sessions here, because for traumatized patients experiencing the music as overwhelming is just triggering flashbacks and by that is not helpful. On the other hand, I do not think it is as terrible as some therapists think – when it happened to me in the early phases of therapy, it also happened every day several times outside the therapy – but I would see it as a sign that this music or even GIM in general is too much for this patient at this time.

And: Productive therapeutic work is impossible while the patient is in the middle of flashbacks.

Being filled with the energy of the music – Isenberg-Grzeda's last category – did not happen in my chosen sessions, and it hardly ever, if at all, happened during the first years of my therapy. Maybe it is more important in the integration-phase of trauma therapy, when things from the outside are not all the time perceived as intrusions.

4.2.2.2 Imagery

The subjective use of imagery in GIM can be drawn from the literature in an easier way than it can be done for music, maybe because imagery is closer to words than music. Körlin (2002) describes how working with imagery can help traumatized patients to transform traumatic inner images into symbolic imagery. Cognitive memory and understanding can be established through imagery-work, as well as integration of discursive symbols with analogical symbols and affect. I used reflection on how I used imagery in my GIM sessions in general, and on how I used imagery in particular during the four sessions mentioned above. From these reflections, I developed five categories:

1. Imagery as a way of speaking
2. Imagery for learning
3. Imagery as a way of coping with trauma
4. Imagery as form
5. Imagery as space between client and therapist

Again I will further describe these categories and give examples from my personal therapy.

Imagery as a Way of Speaking

For traumatized persons, speaking often got difficult, not just because the language-center in the brain is blocked during traumatizations. Perpetrators often directly or indirectly forbid talking about the assaults. If the victim is dependant on the perpetrator or a community (family, class, professional community, etc.) that takes the side of the

perpetrator, speaking becomes tricky as the truth is unacceptable to them. On the other hand, speaking about the traumatizations is important for symbolization and therefore for healing. With the help of imagery, I could speak implicitly about the traumatizations or about other things I was afraid of. Instead of saying to my abusive therapist “you are abusing me and I suffer”, I created the imagery of being a pregnant priestess who is assaulted by a group of people including the father of her child.

By using imagery as a way of speaking, attention is drawn not to objective truth, but to truthfulness. Of course, in reality I am no Polynesian priestess, I was not even pregnant at that time, but nobody would argue about it. If traumatized persons tell their trauma-story, often people, including many therapists, try to argue that it cannot be quite true, that they do not believe it. Often the question of guilt stands in between the listener and the survivor. Imagery has more distance to outer reality, and therefore might not trigger personal traumatic memories in the listener as much as the real story. For therapy this is crucial as truthfulness is much more important than outer reality.

Imagery for Learning

Again in the same session, I practiced flight in my imagery shortly before leaving my abusive therapist:

I am on an island in French Polynesia many years ago. War. I am a pregnant priestess. The enemies want to use me for their power. I would never agree. I would rather die. My people try to save me getting a canoe. The father of my child appears. He is one of the enemies. He wants me to stay. I am half dead. I decide to leave. Exhausted. My teacher who is a male priest and another man of my people help me to get into the canoe. The music is helping me too, pushing me into it.

I also tried to learn about love-relationships in the fourth session by observing the couple dancing before my partner and I became a couple. If something does not turn out to be a good solution in the imagery I always have a second, third, etc. chance. It is pos-

sible to get a feeling for something and reflect on it before I do it in the outside world. I even can try out many different options in the imagery without creating any negative effects in the outside. For me as survivor, this kind of inner trying out is very important, because it widens possibilities and makes creativity possible, while the presence of flashbacks, especially when they are not very clear, narrows things down, creates a feeling that I have to do something immediately or get hurt, and by that kills creativity.

Imagery as a Way of Coping with Trauma

Resource imagery can be used for coping with trauma. In the third session, I used imagery for caring for the wounded inner children. I could also create inner helpers, for example the teacher in the first session. When resources are scarce in the outside world or the survivor is too old for really getting a caring, good parent for her inner children, imagery can be used for it. This imagery then can be drawn upon in everyday life. I could for example ask my inner teacher what he would do when I was faced with a difficult situation. Or when I had flashbacks, I could imagine an adult part caring for the wounded child while still other parts could interact with the outside world.

Imagery as Form

Imagery can put problems or states of being into a concrete form: The pregnant priestess who is assaulted by the father of her child brings my therapeutic relationship with an abusive therapist into form. In the third session, imagery became the form of an inner relationship between a wounded child and a caring parent. Imagery can become a form for dissociated inner parts like the wounded child. Imagery can also bring the abstract form of the music into a concrete form: The caring and tender music of Pärt's *Spiegel im Spiegel* became a caring and tender relationship in the imagery and then became a caring and tender relationship between inner parts in everyday life.

Imagery as Space between Client and Therapist

I perceive the imagery as flexible space between client and therapist, which is created by both of them: explicitly by the client, but implicitly also by the therapist through his choice of music, his interventions, his presence, and his attitude. It is me who made this place visible. My transference is expressed in the imagery. In the first selected session, I perceived the imagery as an energy around me which is there to protect me, but it did not reach out to the therapist. Actually it was actively excluding him. The imagery was of fight and flight, similar to traumatic situations. The more tender parts from the inside did not appear. Fight and flight was protecting me from the therapist. In the post-session processing, I did not offer any meaning of the imagery to my therapist, even though the meaning was clear to me, and he was asking for it. Also there, I was hiding in the imagery which I perceived as a protective layer around me.

In the second selected session, the imagery portrayed therapist B as protective against one of my perpetrators. However, I fell silent during the music-listening period still having vivid imagery. The imagery was reaching out to my therapist, telling him that he is helpful, and that his presence feels supportive, strengthening, and comfortable. But I was too afraid of rejection and abuse to share this imagery with him during the session. I finally did share it in my next session with him a day later. Here I kept reaching out to my therapist and withdrawing, while the imagery itself was clearly reaching out and with that anticipating the building of a good therapeutic relationship.

In the third selected session, both my therapist and I were in the imagery. There were times of extreme closeness between my wounded children and my therapist which felt very direct, as if nothing was between us anymore, but without merging. The imagery provided the space where both of us could be.

Also the imagery of the fourth selected session provided the space for my therapist and me, but with a bit more distance between us. The imagery is of two adults (therapist B and me) watching a couple dancing: "I sit with [therapist B] in the forest a little bit above the glade and watch the couple dancing. The couple cannot see us. I want to learn how to dance like that." The therapeutic relationship has evolved to a trusting

one, where I feel comfortable to voice wishes for the treatment plan (“I want to learn how to dance like that.”). The imagery space is present between my therapist and me in a stable way.

4.2.2.3 Therapeutic Relationship

The therapeutic relationship is not special to GIM, but present in every kind of psychotherapy. For helping and hindering attitudes of the therapist as discussed in the existing trauma literature, see 2.2.2. Besides GIM therapy with three different therapists, I also had other kinds of psychotherapy over longer periods of time. These were mainly psychodynamic psychotherapy with two different therapists and bioenergetic analysis with two different therapists. When reflecting on the therapeutic relationship, I include experiences with these therapists as well. I also experienced cognitive behavioral therapy over a shorter period of time with one therapist. I do not include experiences with that therapist here, because I found the time too short, and the therapy method did not really suit me. When reflecting on my personal therapy, I found the following attitudes and techniques helpful for me:

1. Communication about the therapeutic relationship
2. Mutually and creatively looking for solutions of problems
3. Clarity and transparency from the therapist
4. The therapist admits if s/he does not know something, which should lead to shared reflection on the problem
5. A holding, caring, careful, supportive attitude
6. Therapists should care for themselves both as models, and so that I do not feel like I have to do it
7. Acknowledging the trauma and its effects
8. Taking the side of the survivor (taking a neutral position towards violence means taking the side of the perpetrator)

9. Being able to stay with my pressure and ambivalence towards the therapeutic relationship

All of the traumatizations I experienced happened through people, often through people with whom I had longer relationships. In my life I learned to be afraid of people, to always see people as a source of possible harm and traumatizations. It usually takes many years to learn to trust a person, and even then I do not feel a stable safety in that relationship. This is true for everybody in my life, also for therapists. All of the above mentioned attitudes and techniques I needed to slowly build trust with the therapist, and to mutually create a relationship, that is different from an abusive one, which for me is characterized by:

- A power difference with the victim usually being dependent.
- The abuser controls, builds, shapes, destroys the relationship as s/he pleases.
- The victim has to care for the relationship (and for the abuser) without having the power to do so.
- The abuser keeps destroying the relationship while the victim is dependent on it.
- No real communication about the relationship.
- The victim tries to react to every small cue from the abuser.
- All responsibility is with the victim, while all power is with the abuser.

The therapeutic relationship by nature has power differences. The therapist is more powerful than the patient, no matter how much the therapist tries to avoid this. This is suggestive of abusive relationships, but it also offers the possibility for the survivor to learn about unequal relationships that are not exploitive but caring.

Some attitudes and techniques of therapists I found hindering:

1. An overly protective therapist made me feel incompetent and fostered malignant regression.

2. Power-games, power-struggles. They reminded me of exploitive relationships and triggered flashbacks.
3. Unreflected dual relationships, abusive dual relationships. They are traumatic in themselves. For me in addition they triggered all kinds of flashbacks of old trauma, leaving me with a mix of different traumatic situations all present simultaneously, and an emotional turmoil which led to prolonged freezing and an inability to properly care for myself in the situation at hand.
4. Mindless interventions (for example “Stop dissociating!”).
5. Accusations (“You use dissociation or fear for manipulating.” etc.). Both 4. and 5. showed me that the therapist did not understand me or the effects of trauma. In these situations, I got a feeling that the therapist did not really speak with me anymore, but was rather entangled with his own flashbacks. It felt unsafe because I got the feeling that I was seen as a perpetrator by the therapist, and s/he might any time start fighting against me.
6. The therapist underestimated the importance of him-/herself in therapy. For me even the most evocative music is safer than the relationship to the therapist.

Unlike in the other therapies I experienced, in GIM we work with ASC which sometimes led to regression, and sometimes to transpersonal progression. Depending on the state I was in, I experienced the therapist and the therapeutic relationship in different ways as is shown in Table 4.48.

Table 4.48: Therapeutic Relationship in Regressed and Transpersonal States

Regressed states	Transpersonal states
The therapist feels like a parent	The therapist feels like a witness
I feel very vulnerable	I feel very strong
Anything the therapist says has enormous impact	What the therapist says is not very important
I need the therapist as container	I contain the therapist among other things / persons
Attunement is very needed	Misattunement is impossible
Music and imagery serve as bridge to the therapist	Music and imagery are contained in and expressions of parts of everything
The therapist's attitude is perceived more in ASC	The therapist's attitude is perceived more in ASC
The therapist's attitude determines how I feel / think about myself	The therapist's attitude is noticed and contained, but has no impact on how I feel about myself

(see also Geiger & Maack, 2010)

The table shows that in a regressed state I experienced the therapist like a parent while in a transpersonal state the therapist became a huge container for my experience in which the therapist himself is also contained.

After reflecting on my own therapy process from a client perspective, I constructed the interview guideline (see Appendix) together with my supervisors and the Aalborg group of PhD-students. Through the interviews, I wanted to find out if other traumatized GIM and PITT clients had similar experiences to mine or if they were different, and if they could add things from their experiences. I also wanted to know how it is different and / or similar to have an imagery experience with or without music, and how GIM and PITT were perceived differently as therapy methods by clients.

4.2.4 Results from the Interviews

After reflecting on my own experiences with music, imagery, and the therapeutic relationship, I conducted the interviews with research participants who experienced GIM or PITT in their trauma therapies. The research participants were introduced in 3.3.3.1 and 3.3.3.2. The results of the interviews are given in this part, starting with the roles of music in GIM, followed by the roles of imagery and of the therapeutic relationship both in GIM and PITT. Finally, some other important aspects that were mentioned in the interviews but did not fit anywhere else are presented. In all sections, the results about GIM and PITT are compared as well as the results from the interviews and my personal experiences.

4.2.4.1 Music

In this part, I first give an overview over the roles of music in the participants' GIM therapies. After that, I compare the information from the interviews with my own experience as described in 4.2.2.1.

All four participants (E, H, M, U) described their experiences with music in their GIM therapy as mainly positive. They used words like calming (E, H, U), supportive (E, M, U), safe (E, M), beautiful (E, H), and comforting (H, U) for it. All participants except M used music in their sessions to help them calm down if they got frightened, or if imagery got very challenging. E and U also used music from their GIM sessions at home. It was helping them to calm down when they had flashbacks. For M music itself was already a safe place before she ever had GIM sessions. For E Shenandoah's *Messenger* from the CD *Life Blood* became a safe place. She was able to use this music with her accompanying imagery as flashback-stop both during her therapy sessions and – more importantly – in her everyday life. Both E and H mentioned the beauty of the music. The beauty of the music reminded H of the fact that life is more than just abuse, and that there are also nice and beautiful things and helpful people. E said about it: "It was good to have something beautiful there with all the ugly memories." The comforting quality of music was used by H and U especially in connection with pain. H remembered that sometimes she had painful

body-memories from the abuse. Usually she then brought the music into these places which would comfort the pain. The music felt like a gentle and healing touch to her at these times. H was amazed that music would be able to do this.

All participants except H described the music as very evocative of imagery. They all were ambivalent about this quality of the music: At times they were afraid that the music might trigger flashbacks or bring difficult memories to the surface. At the same time, they wanted to work on these difficult issues and they wanted the music to hold them there and work with them. When difficult issues appeared, the music was experienced as being supportive by all of them.

Music was experienced as different kinds of spaces. M and E experienced the music or a piece of music as a safe place (see above). Music offered also a space for dissociated parts for H and M. H experienced structural dissociation as described by van der Hart et al. (2006) with many inner children, adolescents, and adults but without amnesia. In the music all or some of her inner parts could be there together. For M the music provided a common space for dissociated body parts or for her body and her soul when the soul had left the body. M described the music also as filling the therapy room which made her feel safe there.

In many ways, music appeared as helper in the participants' sessions. Music as helping with comforting pain and calming, as well as music as supportive was already described above. E used the help of strong music to fight perpetrators and to free inner children from traumatic situations. H used music for helping inner parts to be together in a good way. Especially the different voices in the music modeled to inner parts how they can be together without losing their individual identity, but together forming one big whole. U was helped by the music when she started thinking or ruminating during the music listening part of her sessions. The music refocused her on her imagery. M was helped by the music to stay with her imagery and not run away from it when it was difficult.

All of the participants used music somehow to work with dissociated parts of themselves. Music functioned here as shared space for inner parts (H, M), as a good model for being together like the different voices in a piece of music (H), as rescuer of inner parts from perpetrators (E), and as mirror for the inner world (H, U). H said: "The music has different voices and different instruments similar to my inner personalities."

Music also served as a model for calming down (E, H, U), for fighting perpetrators (E), and for different inner parts being together in a good way (H). Calming down in times of pressure and flashbacks and defending oneself against perpetrators are often challenging for survivors. Here especially the contours of music can help finding or creating inner contours for fighting and for calming down.

E and U also used music as transitional object. They both used music at home between their sessions bringing a good object home with them. The music helped both of them to comfort and relax themselves, and to connect to their therapies and to their therapists. U said that imaging with music at home became one way of caring for herself and her wounded inner parts.

After looking at all the functions and roles the participants gave to the music, I now compare them with the categories from my own therapy. I want to see where there are similarities, where the research participants contributed to existing categories of mine, and which categories they added. The categories from my own GIM therapy are:

1. Music as teacher, as keeper of knowledge or abilities
2. Music as relationships
3. Music as space
4. Music as representative of dissociated parts
5. Music as keeper

The modeling functions of music fall into the first category of music as teacher, as keeper of knowledge or abilities. As E, music was also teaching me to fight. In my third selected session, music taught me to calm down, but for me it went beyond just relaxing. Music was

teaching me how to care for a wounded inner part. So music as teacher of relaxation and as teacher of living together in a good way for inner parts can be added to my first category.

My third category – music as space – is also found in the experiences of the research participants. Also for me, music offered space for different inner parts. Music as a safe place in itself and as filling the therapy room and making it safe can be added examples for my third category.

In my fourth category of music as representative of dissociated parts, music mirrored my inner world and my inner dissociated parts similar to H and U, and music modeled different ways of interaction between inner parts and between inner parts and the outer world. Nothing is added by the research participants. They had similar experiences.

Similar to me, E and U use music as transitional object as described in my fifth category: music as keeper. Also here, no further examples are added by the research participants.

The research participants added the following categories:

- Music as bringer or evoker of imagery, music as vehicle into imagery
- Music as helper
- Music as beauty, as connector with non-violent parts of the world

Even though I did not mention these categories when reflecting on my own experience with music, I did experience these categories myself on a regular basis in my own therapy sessions.

4.2.4.2 Imagery

In this part, I first give an overview over the roles of imagery in the participants' GIM therapies. After that, I compare the information from the interviews with my own experience as described in 4.2.2.2. In the last section I give an overview over the use and the roles of imagery in the participants PITT therapies and compare them with the experiences of the participants in GIM therapies (including myself).

Imagery in GIM and Adaptations

Imagery in general was perceived by all the participants who were in GIM therapy as more frightening and painful than the music. E and U could only deal with more challenging imagery because they perceived the music in general as supportive and safe. A reason why imagery was seen as threatening is the fact that it connected to traumatic memories and sometimes brought them to the surface. Even though imagery was perceived as frightening, the participants also connected positive and healing qualities to it:

One way of seeing imagery was as a connector. For the participants imagery is a connector between the inside and the outside world (E, M), between their symptoms and their traumatic pasts (E, H, M), between dissociated inner parts (E, H, U), and to traumatic memories (E, M). An imagery E shared during her interview is a good example of imagery as a connector in different ways: One imagery-scene stood especially out for her. It was a memory of early childhood that she had forgotten. In this imagery she experienced herself as a 3-year-old child witnessing a murder without any of the murderers noticing her (connection with traumatic past, connection with inner part). She was able to relate many of her disturbing feelings to this memory (connection between symptoms and traumatic past), and in the imagery, E could bring the child away from her hiding-place to E's safe place with the Native Americans. Remembering this scene, and taking the time to explore it over many sessions helped E to understand herself better, and to feel compassion with the little girl she was.

Participants also used imagery for learning. Imagery gave them possibilities to change things in the inside (E, H, U), to try out things in the imagery first before doing them in the outside world (E, U), and to learn to calm themselves down (E, H, U). E rescued an inner child from a traumatic scene in the example above. During her beginning phase of therapy, E also had perpetrator contact. Leaving the perpetrators was difficult for her, because the perpetrators were close family members. In her imagery she practiced leaving them over many sessions before she was able to also do it in the outside world. Three of the participants had calming and safe imagery that they also used in

everyday life for affect regulation. E used the image of the Native Americans described in 4.2.4.1. H regularly connected with her inner parts in everyday life, especially when she was afraid and did not know why. Usually she could find a frightened inner child who would tell her what she or he was so afraid of. H then was able to comfort the child and by that get rid of the fear. U created a lot of resource-imagery in her sessions. In her everyday life, she took time to connect with it on a regular basis which helped her with affect regulation.

The research participants used imagery as form, especially for making inner life visible. Imagery became a form for dissociated inner parts (E, H, U), traumatic memories (E, M), and inner processes in general (H, M, U). This in turn made inner life clearer for all of them and helped them to distinguish between present reality and traumatic past (H). A good example for this process is H's experience: She was able to give forms to her dissociated inner parts which made it possible for her to understand her inner life better. When she felt afraid but did not know why, she could both check with her inner parts to see if anyone was in a flashback, or if there was something in the outer reality that was really threatening.

The participants also created resource imagery that could be used in everyday life. Some examples of this were already given above. Resource-imagery for the participants included imagery of inner parts, being able to try things out in the imagery before doing them in the outside world, imagery for calming and comforting, imagery as a help to distinguish between outer reality and flashbacks, imagery as transitional object – for example taking painted pictures from the therapy sessions home – and imagery as flashback-stop.

All participants except M also used imagery as a way of speaking, especially as a way of communication between inner parts. And M used imagery as a way to refocus on her inner life. She said she needed imagery to focus, to be with herself and her feelings, and to not fall asleep with the music.

After looking at the participants' experiences with imagery, I now revisit my own categories describing roles of imagery. They are:

1. Imagery as a way of speaking
2. Imagery for learning
3. Imagery as a way of coping with trauma
4. Imagery as form
5. Imagery as space between client and therapist

All of my categories except the last one can be found in the experiences of the participants as well. The categories that are added by the research participants are:

- Imagery as connector
- Imagery as resource in everyday life
- Imagery as a help to focus

Looking at my own experiences with imagery again, I used imagery as connector and as a resource in everyday life as well, but I did not use imagery as a help to focus.

Imagery in PITT

After looking at imagery in GIM, I now proceed to imagery in PITT. Imagery in PITT is used in two different ways: One way is as described in Reddemann (2004). Only one of the participants (N) experienced this on a regular basis. One more participant (S) experienced it once during her therapy. The other way is the use of imagery-exercises for which either Reddemann's CD is used during the session or the therapist reads a script from her PITT-training. As I did not expect any practice of PITT that was not according to the therapy manual, I consulted with a PITT-therapist who did not take part in the study but knows many colleagues who are also PITT-therapists. She told me that reading the script or using CDs is general practice. If the imagery was not created freely and individually for the participant but read from a script or used from a CD, participants reacted to it in different ways. C, J and S perceived the imagery as something that had to be done right. For them it was rather a learning exercise than a way of expressing themselves, their resources, or

their inner organization. They all could use imagery for learning, but they also all had the feeling that the imagery-exercises at some point hindered resources to be present. C for example only had a feeling of safety in the presence of her partner, but in the safe-place-exercise on the CD it was explicitly said that no persons from the listener's real life should be in the safe place. This made C feel that she could not have a safe place, and the safe place she had – namely her partner – was not right. S said that she found the imagery exercises too manipulative. She would have liked them more abstract, and more individualized. For S the idea of for example “ideal parents” was too concrete, and it triggered her as her parents were also her perpetrators. For her something more open would have been better, for example “someone who is glad that I am there” instead of ideal parents. In one session S's therapist did imagery according to Reddemann (2004). S preferred that. C and J perceived the imagery exercises from the CD or script as diffuse and unclear. They did not understand their purpose in therapy. C also wondered why therapy time is used for listening to a CD that she as well could listen to at home. J did not understand why her therapist would sometimes still read an imagery script of an exercise to her during the session that she could very well do by herself, and that she used in her everyday life on a regular basis.

K's therapist also used the CD sometimes during her therapy sessions. K said that the imagery itself did not work for her, but she used the time to relax and to think about other things or about what issues to talk about later in the therapy session. K had a very busy life with four children, and when the CD run, she enjoyed not having to do anything. She did not follow the imagery from the CD.

All four participants who listened to imagery scripts or an imagery CD during their sessions stated that they could have easily done without the imagery. N on the other hand experienced imagery as described by Reddemann (2004). She said that she very much liked using imagery. Other than the other four participants who had PITT therapy, N felt that imagery tapped into her creativity. For her, using imagery brought something playful and “fun” into the therapy sessions. Besides Complex PTSD, N also had severe vision

problems when she came into therapy. She said that she was quite surprised that since she used imagery on a regular basis, her vision has improved.

Participants from the PITT group used imagery as connector to resources (C, N, S), as connector to creativity (N), to inner parts (N), and to the inner world (N). C said that the tree-exercise connected her with her inner strength as mentioned in the exercise. N in the imagery created her own resource: she developed a house in which every inner part of her had her own room that she could decorate the way she liked. It is noteworthy, that for all PITT participants except for K imagery functioned as a connector to their resources, but only when PITT was used according to the manual, imagery became the participant's personal imagery, it became more lively and alive, and it could do more than just connect to resources.

All participants used imagery for learning. They used it as flashback-stop in everyday life (J, N), and for learning to relax (K, N, S). C described how with the imagery-exercises she was supposed to learn something, but she was afraid that she could not do it right. S even found that the imagery-exercises were manipulating her into something. She said: "I cannot lie to myself as much as the imagery exercises want me to."

Only N could use imagery for making her inner world visible. When she came into therapy she did not have a concept of inner children and adult parts. Working with imagery helped her to get a picture of her inner life. She said: "In the past it took me days or weeks to find out why I felt so scared, lonely, or sad. When I do not feel well now, I look at all the children and adults in my house. Usually I immediately see what is wrong and who of the inner parts does not feel well."

All participants except K used imagery as a resource in everyday life. They used it to connect to their strength (C), as flashback-stop (J, N), to connect with inner parts (N), and for making inner life clearer (N). However, as mentioned above, for some participants imagery was also sometimes hindering a connection with resources (C, J, S).

Comparing the Roles of Imagery in GIM and PITT

Comparing categories of imagery mentioned by GIM and PITT participants, both groups describe the categories of:

- Imagery as connector
- Imagery for learning
- Imagery for making inner life visible (in PITT only if used according to manual)
- Imagery as resource in everyday life

The following categories are only described by GIM participants:

- Imagery as a way of speaking
- Imagery as form
- Imagery as space between client and therapist
- Imagery as a help to focus

While some GIM participants were afraid of what working with imagery might bring up for them, all finally found imagery very helpful and with the help of the music could master the fear. The PITT participants who listened to imagery scripts or an imagery CD saw imagery as an exercise that had to be done right, and for some there was fear of not being able to do so. Some of them also said that they did not understand the purpose of imagery in their therapy sessions. While all the GIM participants and N found imagery an essential part of their therapy, and they could not have gotten where they were without it, the other PITT participants said that it would not have made any difference if imagery would not have been used in their therapies.

4.2.4.3 Therapeutic Relationship

Most of the research participants already had more than one therapist at the time of the interview, and the therapists did not only include GIM or PITT therapists. In the interviews, participants talked about their experiences with all or most of their therapists. They mainly shared what was helpful and what was hindering in their therapists' behaviors and attitudes. As the information I got did not differ very much in the two groups, I report experiences with the therapeutic relationship not separately for the two groups. I start this

section with revisiting what in the therapeutic relationship helped me. Then I look at similarities in the participants' experiences and things they added. After that I will do the same for therapists' behaviors and attitudes that were hindering therapy. In the last part of this section other experiences with and reflections on the therapeutic relationship will be mentioned.

Therapeutic attitudes and behaviors that were helpful for me in my therapy were:

1. Communication about the therapeutic relationship
2. Mutually and creatively looking for solutions of problems
3. Clarity and transparency from therapist
4. The therapist admits if s/he does not know something, which should lead to shared reflection on the problem
5. A holding, caring, careful, supportive attitude
6. The therapist should care of him-/herself both as model, and so that I do not feel like I have to do it
7. Acknowledging the trauma and its effects
8. Taking the side of the survivor (taking a neutral position towards violence means taking the side of the perpetrator)
9. Being able to stay with my pressure and ambivalence towards the therapeutic relationship

In the interviews, participants mentioned points number 2, 3, 5, 7, and 8 as also helpful for them. The other points they did not mention, but I also did not ask about them, so they may or may not have been important for the participants. In general, participants found a warm, calm, understanding, grounded, and competent attitude toward them as helpful. They also liked clarity and transparency from the therapists both about the setup of therapy (for example time, length of session, emergency calls, etc.) and about the therapists' own behavior. M mentioned that it was very important for her that her therapists kept confidentiality. I think this was not mentioned by the other participants not because they did not find it important, but because it is so obviously important. S found it

helpful that her therapist was an outside observer which helped her to better see the reality of her life. All participants said that it was important for them that their therapists supported them with problems of their everyday life. C for example said that her therapist helped her to deal with colleagues she was afraid of. J's therapist wrote a statement so that J could get financial support for moving from one apartment to another.

For all participants it was helpful that their therapists knew about trauma and dissociation and the effects it had on their health. It was important that therapists did not blame participants for the traumatizations they had suffered (E, C, J, N) and that they explicitly made connections between the symptoms the participants had and their traumas (E, C, K, S). Especially for those participants who had strong dissociative symptoms, a skillful approach towards these symptoms and inner parts was perceived as very helpful (H, J, S).

H who was thinking about finishing her therapy at the time of the interview, said it was very helpful for her to know that in times of need she could come back to her therapist. That made it easier for her to terminate therapy. Other participants were afraid of ending therapy because they did not know if and when they could come back to their therapists in times of need because they were dependent on health insurances that might not favor that idea or that would not allow them to go back into therapy with the same therapist for two years after termination (C, J).

Categories of helpful therapeutic attitudes and behaviors that were added by the research participants are:

1. The therapist keeps confidentiality.
2. The therapist as outside observer.
3. The therapist is supportive with problems of everyday life.
4. Knowing one can come back to the therapist for new therapy after termination.

I consider the last one as the most important addition. The first one is obvious and part of every code of ethics. Points number 2 and 3 could fall under mutually and creatively

finding solutions for problems. Personally I consider all four additional helpful therapeutic attitudes mentioned by the research participants also as helpful for me.

After looking at helpful therapeutic behaviors and attitudes, we now come to behaviors and attitude that hinder therapy or therapeutic progress. After reflecting on my own therapy, I found the following (for a more detailed description see 4.2.2.3):

1. Overly protective therapists
2. Power-games, power-struggles.
3. Unreflected dual relationships, abusive dual relationships.
4. Mindless interventions (for example “Stop dissociating!”).
5. Accusations (dissociation or fear is used for manipulation, etc.).
6. The therapist underestimates the importance of him-/herself in therapy.

The research participants experienced points number 2, 4, and 5 as hindering as well. An overly protective therapist or dual relationships were not experienced by the participants at all. It is interesting to note that hindering attitudes and behaviors were mainly reported from past therapists while helpful attitudes and behaviors were mainly reported about the current or – if the therapy is already finished – about the last therapist. This is not only true for my interview partners but also for myself. There might be a number of factors contributing to that: When the therapy is still ongoing there may be a positive transference towards the therapist which might prevent the distance to the therapist necessary for naming hindering attitudes and behaviors. But to a therapist I perceive as helpful I would also go back while I would leave a therapist I perceive as hindering. Another factor may be that knowledge about trauma was less common in the therapeutic community in the past than it is now. So if therapies were longer ago therapists might have just ignored the traumas and tried to treat their traumatized patients similar to neurotic patients. We know today that this would be destined to fail and patients would feel very misunderstood and frustrated.

In addition to the above mentioned points, the research participants found the following therapeutic attitudes and behaviors hindering:

1. The therapist did not say much. It made the participants feel left alone and unsure of what to do or say. (M, J, S)
2. The therapist was too esoteric and not grounded enough. This was reported as confusing and lacking clarity and a base in reality. (S)
3. The therapist sat directly opposite to the participant. This setup gave the participant no choices of where to look. (M)
4. Lying down in analysis (M, S). It is interesting to note that M could not lie down in analysis but had no problems lying down in GIM. She did not know why that was so. As she had male therapists in both methods, it was not due to the therapist's gender.
5. The therapist did not believe the trauma stories of the participant (E).
6. Longer periods of therapist's vacation or absence from work (E, N).
7. Having to leave a session feeling "upside down". (M)
8. Not being able to clarify difficulties with the therapist (E, M, C, S). The reasons for that may be in the therapist (E) or in the participant. M kept saying that it did not occur to her to clarify difficulties in the therapeutic relationship because she was so used to the fact that people did not care about her needs. C was afraid that her therapist might get angry and throw her out of therapy if she tried to clarify difficulties. On the other hand, she described her therapist as warm and understanding. I personally need to feel very comfortable and know the other person very well before I dare to talk about difficulties in the relationship. With my current therapist it is possible but it is always also frightening for me.

Even though I did not mention it in 4.2.2.3, I personally experienced the therapeutic attitudes and behaviors 1, 6, 7, and 8 myself and found them hindering. Numbers 3 I experienced but did not find hindering. I did not experience number 2 and 5, but just imagining them, I would find them quite hindering; and about number 4 I cannot say anything because I cannot really get an idea how it would be to have psychoanalysis as therapy.

In addition to the helpful and hindering therapeutic attitudes and behaviors, two participants added some more general aspects about the therapeutic relationship. U was the only participant who saw her therapists as teachers from whom she can learn things. This might be due to the fact that her first therapist was a cognitive-behavioral therapist. U and J were afraid of becoming too dependent on her therapist. U deliberately made longer breaks into her therapy because of that. J was afraid of becoming too dependent because her health-insurance only allows her a certain number of therapy sessions which at the time of the interview were coming to an end.

J saw the therapeutic relationship as the basis of trauma therapy. She said it was very important to build a firm therapeutic relationship before working on traumatizations or doing imagery work. I personally agree with J. I had no problem, however to work with imagery early in therapy, but this may have been so because I did GIM where I had the music present that could support me, while J did PITT.

The research participants in general could not say much about if and how they perceived their therapists differently during the imagery compared to the rest of the session. N felt her therapist being a bit closer during the imagery, while some of the participants who listened to imagery scripts or imagery CDs felt their therapists being farther away during these times.

4.2.4.4 General Aspects

This section includes statements about GIM and PITT therapy that did not fit into the categories of music, imagery or therapeutic relationship, but that are nonetheless important. The first part of this section contains statements of participants who had GIM therapy, the second part statements of participants who had PITT therapy.

All of the participants who had GIM therapy found GIM very helpful for their processes. They would all recommend GIM to other trauma survivors. None of the participants could imagine having imagery without music or just music without imagery. They all said that it was the combination of music, imagery, altered state and the therapist

that made healing possible for them. The participants said that GIM was especially helpful for changing inner patterns (E, M) or inner structures (H), for getting away from rumination (U), and for enhancing verbal therapy with another therapist or the verbal part of their therapies (M, U). E said that before her GIM therapy, people often went over her boundaries and she would not even have complained about it. Through GIM she noticed that she had internalized that pattern due to her traumatizations, and with the help of GIM she could find ways of setting limits to other people. H described how she got to know her inner structure composed of dissociated parts, and how through GIM she was able to restructure her inner life, so that the different parts could work together in a more constructive way. Both M and U had gotten stuck in verbal psychotherapy before they started with GIM. For both of them it was helpful to work with two therapists simultaneously for a while. They both said that GIM helped them out of the stuck places in their verbal therapies.

E and M talked about the frequency of GIM in their trauma therapies. They both would recommend not using GIM in every session. They both needed weekly GIM for some months during the time they felt stuck which for both was during the beginning of their GIM therapies. Later they preferred less frequent GIM in their sessions. E experienced a new traumatization during her course of therapy. For a few months right after this traumatization GIM was too much for her. She preferred just talking about what had happened. Later she liked using GIM again. M experienced too much music in some of her GIM sessions. She said that if the music listening period was longer than 20-30 minutes in a two-hour session, too much psychic material was brought up, and it could not be covered in the post-session anymore. She then had the feeling of leaving the session “upside down”.

Both M and U at times had another verbal psychotherapist at the same time as their GIM therapists. M said about advantages and disadvantages of having two therapists at the same time: The advantage of having only one therapist would be that she would not have to repeat so much to explain to the other therapist what had happened in her GIM sessions. On the other hand, this could also be an advantage, because it forced her to

put words to what happened in her GIM sessions, which is a way of symbolizing – and symbolization is one of the healing factors in trauma-therapy.

After looking at GIM, we now come to the participants who received PITT therapy. Only N, the only participant who got PITT according to Reddemann's manual, would recommend PITT to other trauma survivors. All the other participants – they listened to imagery scripts or imagery CDs during their therapy – would recommend their therapists to other trauma survivors but not PITT. Usually they said things similar to C: The imagery exercises might help some people, but C could have easily done without them. J and S both would have liked the body to be more included into trauma therapy. Both had briefly encountered body-centered psychotherapy, and they wished their therapists would be able to do something like that, too.

All participants who had PITT therapy are from Germany where trauma therapy is still difficult to find, there are long waiting times, and the number of therapy sessions is limited by the health insurances. They all were angry, frightened or frustrated about that. C in the past once broke her toe and compares the treatment she got for that with the treatment she got for her traumatizations: "This stupid toe was nothing compared to the hurt I have inside from the traumatizations. The symptoms I had from the toe were not even 1 % of the severity of symptoms I have from the traumas. Yet, for the toe I got everything I needed immediately and everybody, even strangers, told me how sorry they were for me. But nobody sees the wounds from my traumas. If I talk about them, only few people feel sorry for me. And for adequate treatment I have to wait for months and then I cannot even have it till I am healed but only till the insurance says it is over. When I broke my toe, it was even my fault. The traumatizations were not my fault at all. Where is the justice here?"

4.2.5 Two Individual Depictions

This part contains two exemplary individual depictions. The first one is of a participant who had GIM therapy, and the second one is of a participant who had PITT

therapy. They serve as typical examples, and are meant to give individual faces to the collection of data given in 4.2.4. Both exemplary individual depictions are originally in German. Here the English translations are displayed. The German originals as well as all other individual depictions can be found in the appendix.

4.2.5.1 Individual Depiction of a Participant with GIM Experience

The individual depiction given here is that of H. Background information about H can be found in 3.3.3.1.

Music:

H likes listening to all kinds of music including classical music but also Heavy Metal and other rather strong and aggressive genres of music. She taught herself to play the guitar a little bit, so that she could play chords and sing with it together with other people.

H did not bring any piece of music that stood out for her. She knew the music her therapist used during her sessions from the transcripts, but she never bought any of it or used it at home. In the sessions she often found music very helpful when the imagery got difficult and painful. It was good to have the beauty of the music there. H experienced the music at those times as contrary to her images. The music helped her to calm down when imagery got heavy. The beauty of the music also reminded her of the fact that life is more than just abuse. There are also nice and beautiful things and helpful people.

H reported that she had many different inner personalities who took over at different times, but she did not experience amnesia. The music was a place where all her different inner personalities could be. “The music has different voices and different instruments similar to my inner personalities.” The music was mirroring her inner world and creating a place for all inner parts where they could be and communicate together. The music also helped her to find good ways of “being together inside”. She gave an example of imagery where different inner parts were present: Some were close together,

another part was completely alone and sad, and yet another part tried to fight and was angry with everybody else. The music helped at that time to create a place where all of them could communicate and find a good place to be. The one who was sad and alone was included; the angry part was heard and acknowledged. H said that the music with its different voices became a model for being together in a good way.

H remembered that sometimes she had painful body-memories from the abuse. Usually she then brought the music into these places which would comfort the pain. The music felt like a gentle and healing touch at these times. H was amazed that music would be able to do this.

Imagery:

Imagery for H often became frightening, especially during the phase when she was working through her traumatizations. She experienced body memories which at times were painful. During these times it was good to have the music there, because it helped comfort the pain.

H was surprised how well imagery would depict her inner life, especially the different parts of herself. It was very healing and a relief to finally have space for all the inner parts. They became much clearer. Also the way she was dealing with the inner parts in her everyday life became clearer: she was mainly trying to push them away or ignore them. In her imagery and together with the music, she learned better ways of dealing with them. Lately she saw her inner parts as resources and as inner wealth rather than as disturbing. At the time of the interview, her inner parts communicated on a regular basis in her everyday life, and there was more harmony among them. H saw this as one of the major outcomes of her therapy so far.

The imagery from the sessions was working through into H's everyday life. Between sessions, she took time to continue communicating with inner parts. This made her life richer and also clearer. Now, when she suddenly feels fear during the day, she would look inside who of her inner parts is afraid and why. This helps her to distinguish present reality from flashbacks. It also helps her to comfort inner parts outside of ther-

apy. H thought that without the imagery-work in therapy she would never have gotten the idea of trying this. She would not even have been aware of her inner parts.

Therapeutic relationship:

Without even me asking about it, H shared an image of her therapist and the therapeutic relationship. Asked about her therapist, she immediately said: "My therapist is like a good mother for all my inner children. And she is teaching me to be that good mother myself."

For H it was crucial that her therapist knew about trauma and about dissociation and working with inner personalities. Her therapist was gentle with the frightened and hurt inner children, but still gave space and listened to the angry personalities. She helped H see that some inner personalities behaved like perpetrators, but that underneath usually they were frightened little children. Without her therapist, H would have gotten the idea of just fighting these personalities and not seeing who they really were. It was during the music-listening-periods that her therapist asked about the feeling of these perpetrator-like parts. When H was feeling into them without too much fear, she could feel their fear and helplessness and how small they really were. Without her therapist she would have been too scared to look at them this way. H knew that in case these parts would have been real perpetrators, her therapist would have been there to help her.

H liked the clarity of her therapist. She knew exactly what she could expect from her and what she could not expect. However, sometimes H got angry with her therapist. Once she was late for her session and her therapist was already gone. H knew that if she was late, she was supposed to call her therapist. Still H was quite frustrated when she found out that her therapist was gone and she would not have a session that week. It felt like her therapist did not see how bad she was feeling and how much she needed the therapy.

H and her therapist thought about the end of therapy at the time of the interview. H thought that she had gained a lot and that she got many good tools for working with

her inner world. She also worked through much of her traumatizations. H really liked it that her therapist offered her to come back for single sessions or very brief periods of therapy after finishing. It made her feel safer, and it helped her towards finishing therapy. She said: "Like this I know that I do not have to wait till I feel really bad again. I can go back to my therapist if I need it, even just for a session or two. And maybe I will not even need it, who knows ...". She also said like this her inner children did not feel abandoned. They could see their therapist again if they want and need.

General aspects:

H found GIM very helpful. For her it was the combination of therapist, imagery and music that really helped. She thought that she could not have done the same if any of these components would have been missing. H saw the work with music and imagery as food for the verbal sessions. The verbal sessions were important for processing the material from the music and imagery sessions. But H could not imagine doing therapy without GIM. She said: "Then the main component would be missing. I could talk a bit about everyday problems or traumatizations from the past, but the main thing – the creative space for making clear how my inner parts are and for finding a new and better inner structure – would be missing." H was sure that she never would have gotten as far as she got without the GIM.

H would recommend GIM to other trauma survivors, especially to those who have several different inner personalities and to those who like music. But the therapist must know and have experience with trauma. H thought that GIM is a rather quick way of working without it being too overwhelming.

H said that even though the images that came up sometimes were frightening, she also enjoyed the GIM sessions. The music was beautiful, and she always was curious about what would come up from the unconscious. It was also fun to be creative with the material, to see how inner parts could live well together, or to see how sometimes what she thought should work did not work. She had the freedom to try out things inside, and have both the music and the therapist as helpers.

4.2.5.2 Individual Depiction of a Participant with PITT Experience

After the individual depiction of a participant with GIM experience, we come to one with PITT experience. I chose S as a typical example. S's background information can be found in 3.3.3.2.

Imagery:

Imagery exercises were embedded in her verbal psychotherapy. The therapist usually used Reddemann's CD during the sessions. Once her therapist created the imagery herself (no CD, not read from a script). S found that more helpful than the CD. She perceived Reddemann's voice as very unpleasing. Her first impulse when hearing the CD for the first time was to turn it off. S did not perceive her therapist differently during the imagery exercises than during the rest of the session.

When I asked about imagery, S's first reaction was: "I am not so responsive to this stuff." She found the imagery exercises too cloying. Nevertheless, imagery in general was relaxing for her.

Some imagery exercises did not work at all for S, for example "ideal parents" and exercises where one has to remember moments of strength in one's life. About the latter she said that she did not have such moments. S's therapist answered that they would have to see to it that S would experience such moments, so that later she could remember them. S has done the "tree-exercise" on a regular basis. She found this exercise down-to-earth. S changed the tree-exercise so that she imagines being the tree herself and creating a bark for protection. This helped her to center herself and to protect herself against draining people. Her partner was one of those persons.

For relaxing, S also remembered a beach from her childhood. One had to walk for two hours to get there. There were "birds, sand, and – other than that – nobody".

Because of a car accident, S had tried to work with EMDR in her therapy. They had to stop it, however, because physical symptoms – especially nausea – became overwhelming. The nausea stayed for a long time afterwards. Finally she could get rid of

it with the help of a spiky massage ball. In her everyday life this nausea sometimes had stayed for up to two weeks without her knowing where it came from.

With the imagery exercises S found it hindering that they were “too flowery, too rose-colored”. It would have been better for her if they were more prosaic and abstract. She found that the exercises dealt too concretely with one specific thing, and were not individualized enough. For example in the exercise “ideal parents” it would have been better for her if “parents” would not have been specified; rather her therapist could have her find someone who is happy that she exists. Like that it would have been less fixed in one particular image. For S the exercise “ideal parents” was difficult because she could not imagine parents being like that. Parents were triggering her.

If S had worked without imagery in her therapy, it would not have made a difference for her. She said: “Imagery work is good for some patients but not for others.” For herself chanting¹³ is more helpful than imagery work.

Therapeutic relationship:

S said about her therapist her “intellect and heart are in the right places”. It helped S to speak about her traumatizations in therapy because her therapist knew about trauma sequelae. She felt understood. She liked that her therapist was down-to-earth and scholarly but with a female, motherly component. Her therapist was a pleasant person. She was honest, sincere, competent, and she told her when she got to her limits. It was helpful for S to be able to cast her cares in therapy and that the therapist kept the role of an outside observer. The therapist gave positive feedback to S and by that calmed her “nasty inner censor”. S tended to criticize herself in a very destructive way. Her therapist brought her back to reality by telling her all the things she did well. S could not do that for herself. It was also good that S could bring anything she wanted into therapy.

If S did not come into a therapy session with clear issues, her therapist would make suggestions. S found that helpful. Also developing tasks for everyday life was

¹³ Chanting was never used in her therapy. S learned it in Buddhist workshops.

helpful for S. Her therapists helped S to keep good structures in her life. She would recommend her current therapist to other trauma survivors.

The experiences S had in traditional analysis were not as good. She was supposed to lie down on the couch, and she did not want that. She perceived her therapist as too distanced. He sat too far away. Then he frightened S with sudden closeness: when she was lying on the couch he suddenly touched her head. She perceived that as too intimate. It was also difficult for S that her previous therapist did not ask anything, and she just did not know what to say. She did not know how therapy works, and he did not explain it to her. It was also difficult for S that “he had bathed in perfume”. It was too pungent and S got nausea from it.

A too flowery or esoteric attitude of the therapist would also be hindering for S. But that was neither the case with her current therapist, nor with her analyst.

In her current therapy, it was hindering that the therapist urged S to sort out her job situation. That was too much. But S was able to confront her therapist with that and to make clear that she needed to go step by step. The therapist explained to S that she had thought, S had dissociated from her job situation and therefore had not dealt with it. It was good for S that the issue could be solved in therapy.

As an image for the therapeutic relationship with her current therapist, S described two trees that were standing close to each other. She was one of the trees and the therapist was the other one. S had a dark brown bark; her therapist had a light, smooth bark with shades of green. Both trunks were thick. For S the trunks were important. It was not so important which type of tree they were. “The trees understand each other. One is not alone.” S also said about the therapeutic relationship, she and her therapist were a good team – “she as therapist, and I as patient”.

General aspects:

In general it was helpful for S to understand what happened with her for example when she dissociates or when she had flashbacks, and how somatizations came about. As resources in everyday life, S described a feeling of being one with nature, and her

spiky massage ball that she always carried with her. Also chanting as Buddhist meditation she perceived as helpful. For her, it brought serenity, a sober mind, centering, and balance. After that she usually felt ready for the day. When S learned this meditation, she had some problems because after a while she used to fall into trance. At the time of the interview she always kept the chanting meditation short, so that that did not happen. She used chanting especially in times when she feels very bad.

S would like to have Somatic Experiencing by P. Levine or another kind of body-centered psychotherapy as part of her therapy and reimbursed by health insurances. She thought that more could be achieved if the body was included in trauma therapy.

4.2.6 Creative Synthesis

After looking again at all the data from my reflections and from the interviews, I first want to give a musical picture of what it feels like to be in therapy as a person having survived multiple traumatizations, then I look at the treatment, and finally at treatments and theories that are still missing.

Two pieces of music came to my mind that depict the therapy situation:

1. Hugo Alfvén, Symphony No. 5 in A minor (op. 54), 3rd Movement; and
2. Gabriella's Song from the soundtrack of the film "As It Is in Heaven".

The Alfvén to me depicts a territory where any time anything could pop up. The soundscape has high tension throughout the piece. The composer uses special effects that create sounds or interactions of instruments not frequently heard. Living with Complex PTSD is like running a constant obstacle course. Any time triggers might occur that create alarm reactions and flashbacks. When triggers are known, they often can be avoided as long as life does not change much. Whenever there are bigger changes in life, more triggers appear that the person was not aware of. Therapy offers the possibility to work on traumatizations which gives hope but also brings lots of triggers all the time. It can throw a person from one flashback to the next, sometimes one flashback triggering the next, bringing more and more frightening and not consciously remembered sounds, smells,

bodily sensations, fears, etc, and also bringing long forgotten inner parts suddenly to the forefront. The Alfvén gives a picture of all the threatening material that can suddenly come up from deep inside and produce trauma reactions. It also shows the dynamics of appearing flashbacks, namely sudden, unexpected, interfering, loud, or just quietly sneaking in. If normal life for a trauma survivor is like an obstacle course, therapy is like a mine field.

Gabriella's Song on the other hand depicts tenderness, strength, determination to try to live as full a life as possible despite everything. The solo voice to me is like the survivor in therapy when flashbacks and trauma reactions are not interfering directly. The chorus and the orchestra are like a good therapist, supportive, taking the side of the survivor, hopeful, strong, and offering a form of vitality (see Stern, 2010) that is not typical for assault, trauma, or trauma reactions. The music itself is building to a peak without being threatening. This building of energy is depicting the ever fuller life that can become possible through therapy.

In therapy sessions to me it is as if both pieces are playing simultaneously. Sometimes one piece is louder, sometimes the other. If for example the therapist herself is triggered by the flashbacks of the patient, or if the therapist goes into power games or power struggles, *Gabriella's Song* almost cannot be heard anymore and the Alfvén becomes very loud. If traumatizations are completely avoided, the Alfvén recedes into the background – ready to come back any time – while *Gabriella's Song* is loud. Both pieces are needed in therapy, and the therapist sometimes needs to turn up the one or the other more.

Simple resource-oriented imagery-exercises or strengthening resources in the first GIM sessions can help trauma survivors to better avoid mines, to better care for smaller wounds after being hit by a mine, and to go around obstacles. *Gabriella's Song* is turned up. If the imagery is not individualized to the patient, however, the chance is big that it may contain mines that either hurt the patient or that the patient avoids ("Imagery is not for me."

or “I cannot do imagery.”). That is as if pieces of the Alfvén mixed into *Gabriella’s Song* were delivered by the therapist which creates an unpredictable mesh.

Both music and the therapist in this first phase and later can model new forms of vitality for affect regulation, for dealing with people, and for dealing better with everyday life – and music can even model forms of vitality that the therapist cannot or does not model himself. Using these models from the music and the therapist, later in therapy better inner structures can be built, first using imagery, and then in real life. Maybe the new inner house is built far away from the mines, so that the mines become less important. Or the mines are still in the backyard, but there are signs. Usually therapy ends there, as the patient feels much better, has more control, a better inner and outer organization, a clearer picture of his inner life, and feels stronger. *Gabriella’s Song* is loud and strong, but Alfvén is still playing quietly and undisturbed underneath. An unintentional move from the survivor or someone or something else might have a mine explode again – *Gabriella’s Song* is gone, Alfvén is in the foreground.

I believe that by chance in GIM (not in modifications), sometimes mines are defused, and obstacles are removed, even though up to now there is neither a theory nor a defined treatment for it. In very late phases of therapy, the inner wisdom of a patient might lead her to do this with one or two mines (of several hundred), as GIM leaves an open enough space for it. Learning more about mines, what they are, where they are stored in the psyche, and how to defuse them are still areas for future research. Then Alfvén can be turned off and be replaced, for example by Vaughan-William’s *Lark Ascending*.

Chapter 5: DISCUSSION

This chapter is a discussion of the findings of this study. It starts with a summary and discussion of the meaning of the results outlined in the previous chapter. It is followed by a discussion of the findings in relation to previous research. In this part the overall efficacy of GIM and PITT, as well as the findings of this study related to the theoretical basis of the two methods are discussed. The next part looks at the limitations of the study which include limitations inherent in the research design, the researcher's therapy allegiance, differences in the participants' nationalities, and some limitations due the qualitative research method used here. A part discussing the clinical applications and applications for GIM and PITT training follows. The chapter is finished with directions for further research and the conclusion.

5.1 Findings

5.1.1 The Efficacy of GIM and PITT in the Treatment of Complex PTSD

The first question of this study was: *Is GIM, PITT, or both of these methods indicated for severely traumatized women?* This was tested through the quantitative part of the study. Symptoms of Complex PTSD were tested by the SIDES-SR (main outcome), symptoms of structural dissociation by the DES-T, symptoms of somatoform dissociation by the SDQ-5, interpersonal problems by the IIP-PD25, and factors promoting health by the SOC. The results reported in section 4.1.2 show that the reduction of symptoms of Complex PTSD, structural dissociation, and the reduction of interpersonal problems was greater for the women treated with GIM or PITT than for the control group. Also the increase of factors promoting health was greater for the women treated with GIM or PITT than for the women of the control group. Over the 50 therapy hours, PITT showed a small to medium effect size in the areas of structural dissociation and interpersonal problems.

GIM showed a very large effect size in all three areas. Effect sizes for symptoms of Complex PTSD and for interpersonal problems could not be computed because there was no homogeneity of variance between the three groups, so that nonparametric statistics were necessary. Symptoms of somatoform dissociation were only reduced in the GIM group. The symptoms of the PITT group in this area did not change while symptoms of the control group worsened. In the area of somatoform dissociation GIM had a very large effect size, PITT had a small negative effect size, and waiting had a very large negative effect size. Comparing the results of the GIM group at posttest with the separate but matched follow-up group suggest that in the areas of dissociation, interpersonal problems, and factors promoting health, the outcome is stable after finishing therapy. In the area of symptoms of Complex PTSD the follow-up group has significantly better results than the GIM treatment group at posttest. This suggests that more therapy might further alleviate the symptoms and that the positive results remain after finishing therapy or that symptoms of Complex PTSD might continue to improve over time after termination of therapy.

Women who were on waiting lists for trauma therapy (control group) showed a large increase of symptoms of Complex PTSD, structural and somatoform dissociation, and interpersonal problems, as well as a large decrease of factors promoting health. At least nine months of waiting for trauma therapy showed a very large negative effect size in the areas of structural and somatoform dissociation and in factors promoting health. These results indicate that for women who had to wait about a year (40-66 weeks) for their therapies, it would need about 25 hours of treatment with GIM, or about 150 hours of treatment with PITT just to improve their health again to the level it had before waiting.

Comparing the outcome of treatment with GIM and treatment with PITT, reduction of symptoms and improvement of factors promoting health were significantly larger on all applied measures for women treated with GIM. The results suggest that treatment with both GIM and with PITT are indicated for severely traumatized women, but GIM would be the

treatment of choice unless it is contraindicated for other reasons¹⁴. The results further suggest that waiting for nine months or more for trauma therapy is contraindicated for severely traumatized women.

The second question of this study was: *When would GIM and when would PITT be indicated?* This was tested both through the quantitative and the qualitative parts of the study. The quantitative outcome would suggest that GIM would always be indicated, and PITT would be better than waiting but not the treatment of choice for women with Complex PTSD. This outcome, however, might be due to the fact that most probably in many cases PITT was not conducted according to Reddemann's manual. This was reported by four of the five interview partners who received PITT. Instead of spontaneous, free, and individualized imagery, therapists used standardized imagery scripts or an imagery CD during the sessions. The data do not indicate for how many participants from the quantitative study this was true. Research question 2 will further be discussed in 5.1.2.

5.1.2 Music and Imagery in GIM and PITT for Women with Complex PTSD

In this section the roles of music and imagery in GIM, as well as the roles of imagery in GIM and PITT are compared to further answer the second research question (see 5.1.1), and the third research question: *What are different roles of music in imagery-based trauma therapy?* This was explored in the qualitative part of the study. Table 5.1 gives an overview over the roles of imagery in GIM and PITT as well as over the roles of music in GIM. The results are reported in detail in section 4.2.

¹⁴ This includes contraindications for the use of GIM like for example active substance abuse or an acute psychotic episode.

Table 5.1: Roles of Music and Imagery in GIM and PITT

PITT Imagery	GIM Imagery	GIM Music
<i>Imagery for learning</i> <ul style="list-style-type: none"> • flashback-stop • to calm oneself 	<i>Imagery for learning</i> <ul style="list-style-type: none"> • to calm oneself • to fight • about relationships • trying out things in the imagery 	<i>Music as teacher, as keeper of knowledge or abilities</i> <ul style="list-style-type: none"> • model for being in relationship • for calming oneself • model for fighting perpetrators • for speaking the truth • model for caring for inner parts
<i>Imagery as form*</i> <ul style="list-style-type: none"> • make inner life visible 	<i>Imagery as form</i> <ul style="list-style-type: none"> • make inner life visible • to concretize problems 	<i>Music as representative of dissociated parts</i>
<i>Imagery as connector</i> <ul style="list-style-type: none"> • to resources • to creativity* • to inner parts* • to the inner world* 	<i>Imagery as connector</i> <ul style="list-style-type: none"> • between inner and outer world • between symptoms and trauma • between dissociated inner parts • to traumatic memories 	<i>Music as beauty, as connector with non-violent parts of the world</i>
<i>Imagery as resource in everyday life</i>	<i>Imagery as a way of coping with trauma</i> <ul style="list-style-type: none"> • resource imagery 	
	<i>Imagery as space between patient and therapist</i> <ul style="list-style-type: none"> • expression of transference 	<i>Music as space</i> <ul style="list-style-type: none"> • music as safe place • space for dissociated parts • keeping space between war parties • space for trying out relationships • space for healing
	<i>Imagery as a help to focus</i>	<i>Music as helper</i> <ul style="list-style-type: none"> • for comforting pain • for calming • for fighting perpetrators • help inner parts to be together in good way • for focusing and staying with imagery
	<i>Imagery as a way of speaking</i> <ul style="list-style-type: none"> • communication between inner parts • speaking with the therapist in metaphors • going around the prohibition to speak 	
		<i>Music as relationships</i> <ul style="list-style-type: none"> • model for different kinds of relationships
		<i>Music as keeper</i> <ul style="list-style-type: none"> • music as transitional object • keeper of abilities that are suppressed by outside
		<i>Music as bringer or evoker of imagery, music as vehicle into imagery</i>

* This was only reported by the participant who experienced PITT according to Reddemann's manual

The table shows that imagery can be used for learning, as connector, and as resource for coping with trauma in everyday life both in GIM and in PITT. It can also be used as form in PITT and in GIM, when PITT is conducted according to Reddemann's manual. However, in PITT the focus in these areas is strictly on calming oneself and on resources while in GIM the focus is broader. When PITT is conducted to Reddemann's manual, the focus also becomes broader. In GIM imagery is used as space between patient and therapist, as a way of speaking, and as a help to focus. The functions of imagery as a resource in everyday life and as a way of speaking have no parallel in the roles of music. It needs imagery to fulfill these functions.

On the other hand, there are roles that only music has. These are music as relationship, music as keeper, and music as bringer and evoker of imagery. In addition there are roles that both imagery and music have in GIM, but they are somewhat complementary. Both imagery and music can be used for learning, but while music is like the teacher who models things, imagery offers the possibility for trying these things out. Both imagery and music can be used as form, but while imagery is a very concrete form, music is a rather abstract form, maybe more a suggestion of form. The same is true for music and imagery as connectors: Imagery portrays clear connections while music gives abstract and indirect suggestions for connections. Both music and imagery can be perceived as space. Here it is the other way round: music is the more concrete space where many things are possible. It offers space for imagery to take form. Imagery also is a space, but in a more abstract and hidden way. It mainly gives space for the expression of transference. The same is true for music and imagery as helper. Music can be perceived as a third person in the therapy room that is actively helping the patient. Imagery is more of an indirect and abstract helper for focusing, and for keeping with the story and the issues at hand.

To answer the second research question: PITT would be enough if the focus of the therapeutic work should be limited to resources and to calming oneself¹⁵. GIM can

¹⁵ PITT has more possibilities if conducted according to Reddemann's manual.

also do that, but it goes much beyond that and offers the possibility to restructure the inner self.

The roles of music (third research question) for severely traumatized women are:

1. Music as teacher, as keeper of knowledge or abilities
2. Music as relationships
3. Music as space
4. Music as representative of dissociated parts
5. Music as keeper
6. Music as bringer or evoker of imagery, music as vehicle into imagery
7. Music as helper
8. Music as beauty, as connector with non-violent parts of the world

The third research question has two sub-questions. The first sub-question is: *What could music be particularly helpful with?* This question already has been answered above. The second sub-question is: *Are there limitations in the use of music?* This study cannot answer this question. The results suggest that there are no limitations. However, from my own experience as a clinician I know that for some traumatized patients music can be too much at times or in general. As this usually becomes clear during the first 2-3 sessions, most probably these patients were just not taken into the study. To answer this sub-question it would need another study with a different design (see also 5.5).

5.1.3 General Characteristics of the Treatment of Women with Complex PTSD

The fourth research question of this study was: *What are characteristics of the treatment of patients with Complex PTSD?* This was explored in the qualitative part of the study. The participants and I reflected about the therapeutic relationship and other general aspects of trauma therapy. The following therapeutic attitudes and behaviors were helpful for the participants:

1. Communication about the therapeutic relationship

2. Mutually and creatively looking for solutions of problems
3. Clarity and transparency from therapist
4. The therapist admits if s/he does not know something, which should lead to shared reflection on the problem
5. Holding, caring, careful, supportive attitude
6. The therapist should care of him-/herself both as model, and so that the patient does not feel like she has to do it
7. Acknowledging the trauma and its effects
8. Taking the side of the survivor (taking a neutral position towards violence means taking the side of the perpetrator)
9. Being able to stay with the patient's pressure and ambivalence towards the therapeutic relationship
10. The therapist keeps confidentiality.
11. The therapist as outside observer.
12. The therapist is supportive with problems of everyday life.
13. Knowing one can come back to the therapist for new therapy after termination.

Participants also reported therapeutic behaviors and attitudes that hindered the therapeutic process:

1. Overly protective therapists
2. Power-games, power-struggles.
3. Unreflected dual relationships, abusive dual relationships.
4. Mindless interventions (for example "Stop dissociating!").
5. Accusations (dissociation or fear is used for manipulation, etc.).
6. The therapist underestimating the importance of him-/herself in therapy.
7. The therapist did not say much. It made the participants feel left alone and unsure of what to do or say.

8. The therapist was too esoteric and not grounded enough. This was reported as confusing and lacking clarity and a base in reality.
9. The therapist sat directly opposite to the participant. This setup gave the participant no choices of where to look.
10. Lying down in analysis. It is interesting to note that the participant could not lie down in analysis but had no problems lying down in GIM. She did not know why that was so.
11. The therapist did not believe the trauma stories of the participant.
12. Longer periods of therapist's vacation or absence from work.
13. Having to leave a session feeling "upside down."
14. Not being able to clarify difficulties with the therapist. The reasons for that may be in the therapist or in the participant.

Besides the attitudes and behaviors of the therapist, participants found it very difficult when they had to wait for trauma therapy when they needed it. The fact that making trauma survivors wait when they seek therapy is contraindicated is also confirmed by the results of the quantitative part of the study. The symptoms of the participants from the control group worsened significantly during the time of waiting. Another difficult part was the limitation of therapy sessions by some health insurances in Germany. That longer therapies seem to be necessary for women with Complex PTSD is also confirmed by the number of therapy hours participants from the control group had. These women had 26-300 hours of therapy with a mean of 165 hours. Only four of the 34 participants from the follow-up group needed less than 100 hours of therapy. In Germany, most of the time health insurances limit the amount of therapy hours to 100. In some other countries it is even less than that. In the next part, these findings are discussed in relation to previous research.

5.2 Findings in Relation to Previous Research

5.2.1 The Overall Efficacy of GIM in the Treatment of Complex PTSD

This is the first empirical outcome study of GIM and its adaptations focusing only on patients with Complex PTSD. However, there are a number of case studies in which GIM with traumatized patients is described, as well as a study that looked at group treatment using also GIM in general psychiatry (Körlin, Nybäck, & Goldberg, 2000). In the latter the authors compared the outcome in the areas of psychiatric symptoms, interpersonal problems, and factors that promote health for traumatized and non-traumatized psychiatric patients. These studies are described in 2.3.7.

The described outcomes of the case studies were:

1. finding and trying out resources
2. increased self-esteem
3. getting in touch with and working through feelings and emotions
4. greater sense of hope
5. increased relaxation
6. decreased hypervigilance
7. reduction of intrusive thoughts
8. anger control
9. decreased addiction
10. decreased numbing.

Number 2, 4, 5, 6, 7, 8, and 10 are symptoms that were asked for in one or more of the questionnaires used in this study. So this study may confirm results from the case studies. It should be noted, however, that none of the questionnaires from this study focused only on one of these symptoms.

Körlin, Nybäck, and Goldberg (2000) found that traumatized patients improved significantly more in the areas of general psychiatric symptoms (measured by the SCL-90), interpersonal problems (measured by the IIP), and factors promoting health (measured by the SOC) than non-traumatized psychiatric patients after four weeks of creative arts group

therapy into which group GIM was included. The results of the present study, which examined the effects of individual GIM sessions in outpatient psychotherapy are consistent with the findings of Körlin, Nybäck, and Goldberg (2000). Snekkevik et al. (2003) found that scores of the SOC-13 are not stable over time for severely traumatized patients. This is confirmed by the present study. They further found that SOC scores for this population were associated with life satisfaction. Low SOC scores in their study were “related to being or not being in a state of anxiety” (Snekkevik et al., 2003, p. 443). Körlin, Nybäck, and Goldberg (2000) found significant results in the SOC subscales of Comprehensibility and Meaningfulness, but not in Manageability. These findings from Snekkevik et al. (2003) and Körlin, Nybäck, and Goldberg (2000) may also be true for participants from this study.

The literature review includes outcome studies of cognitive therapies and psychodynamic therapies for patients with Complex PTSD and dissociative disorders. Usually medium to large effect sizes are reported when comparing pre- and posttest measurements, but drop-out rates went up to 50 % and non-response rates sometimes far exceeded 50% (Brand et al., 2009; Cloitre, 2009; Schottenbauer et al., 2008). In the GIM treatment group there was no drop-out. This may be due to the fact that research participants chose their therapists instead of being randomized to a therapist. Wampold's (2001) study on therapists' effects supports the hypothesis that “the particular therapist delivering the treatment is absolutely crucial” (Wampold, 2001, p. 202). I would consider it impossible to talk with a therapist with whom I do not feel comfortable – and who may trigger me in many ways – about issues involving pain and feelings of shame and guilt. In the area of dissociation, fewer than 9% of the participants from this study were still above the cut-off line on both measurements at posttest compared to more than 70% at pretest. And while all of the participants scored below average in the area of factors that promote health (SOC-13) at pretest, 74% were above average at posttest. All participants from the GIM treatment group improved in the areas of structural dissociation and factors that promote health. In the area of somatoform dissociation, two participants (5.9%) did not

change while all the others improved. The other scales do not have cut-off lines or a reported average for the general population; however, all participants from the GIM treatment group improved both in the area of symptoms of Complex PTSD, as well as in the area of interpersonal problems. Treatment with GIM in this study shows no drop-out and very low non-response rates compared to other state-of-the-art treatments for Complex PTSD.

5.2.2 The Overall Efficacy of PITT in the Treatment of Complex PTSD

There are two outcome studies of PITT. Both were looking at an in-patient population. These studies were described in 2.4.1. This study confirms the reduction of symptoms of structural dissociation as measured with the DES through PITT. It indirectly also confirms the improved abilities in self-soothing and calming oneself. In this study these abilities among many other things were part of the SIDES-SR, but also participants of the qualitative part of the study kept reporting that PITT helped them with self-soothing and calming themselves.

PITT showed a low to medium effect size in the areas of structural dissociation and factors that promote health, and a small negative effect size in the area of somatoform dissociation. Compared to other state-of-the-art trauma therapies like Cognitive Therapy or EMDR, the effect size of PITT in this study is rather small.

Also in the PITT group, there was no drop-out. The reasons for that most probably are similar to those of the GIM treatment group. The low drop-out rate is discussed in 5.2.1. The non-response rates for PITT are in the average range of treatments for Complex PTSD. While at pretest 23.5% of the participants treated with PITT were above the cut-off line for structural dissociation, less than 6% were above cut-off at posttest. In the area of somatoform dissociation, fewer participants got below cut-off with the help of treatment: 59% were above cut-off at pretest, and 38% at posttest. In the area of factors promoting health, there was no change in percentages of participants below or above average through treatment. About 70-80 % of the participants of the PITT group improved through treatment in the areas of symptoms of

Complex PTSD, interpersonal problems, and factors promoting health, while in the area of dissociation only 38-50 % of the participants improved.

5.2.3 Findings Related to the Theoretical Basis

In this part I discuss mainly the findings from the qualitative part of the study in relation to the theoretical basis of GIM, PITT, and trauma therapy. In the first section the therapeutic relationship is discussed. The findings from both participants who experienced GIM and those who experienced PITT are used because there were no major differences. The second section is a brief discussion on the findings in relation to theory of PITT. I kept this section short because I never experienced PITT personally nor am I a PITT therapist. I believe that the main theory building of a method should be done by those practicing and teaching it. In Sections 3 and 4 the theoretical basis of music and imagery in GIM in relation to the findings is discussed.

5.2.3.1 The Therapeutic Relationship and General Aspects of Trauma Therapy

In this section factors are discussed that influence recovery after trauma as well as helpful and hindering attitudes and behaviors of therapists in trauma therapy. Factors that influence recovery are described in 2.2.1. Many of them are inherent in the person of the trauma survivor or are related to the childhood of the survivor. These factors are not discussed here as they were not researched in this study. Positive and protective factors that are related to trauma therapy reported in 2.2.1 are:

1. Social support (Fischer, 2000).
2. Reliable and supportive significant other at adult age (Fischer, 2000; Birck, 2001).
3. The traumatized person could talk about trauma(s) in therapy and/or with other persons and the trauma is acknowledged (Birck, 2001; Huber, 2003; Tedeschi & Calhoun, 2004a).
4. Longer period of psychotherapy (Birck, 2001; Huber, 2003; Steele et al., 2001)

5. The patient was satisfied with prior therapies (Birck, 2001; Fischer, 2000)

Negative factors that are related to trauma therapy reported in 2.2.1 are:

1. Lack of social support after the trauma (Brewin, 2003; Huber, 2003)
2. Missing acknowledgement of trauma by others (Huber, 2003).
3. Posttrauma life stress (Brewin, 2003; Huber, 2003)
4. Breaking off therapy without proper termination initiated by client or therapist (Birck, 2001; Fischer, 2000).
5. The patient was not satisfied with prior therapies (Birck, 2001; Fischer, 2000)

The protective factors 1-3 and the negative factors 1-2 have to do with acknowledgement of trauma and its effects and support by others who may or may not be therapists. These factors were reconfirmed by the research participants of the qualitative part. They are indirectly also confirmed by the outcome of the control group. Their symptoms worsened significantly during the time they had to wait for therapy. I assume that they were lacking support and missed acknowledgement of their traumatic history and its effects. Maybe they were even faced with posttrauma life stresses or new traumatizations and left alone with them for at least nine months. Longer periods of therapy are also mentioned as a positive factor. The therapies of some of the interview partners were paid for by health insurances that limited the amount of therapy sessions usually to about 100. It made these interview partners feel afraid, insecure, and angry. The data from the GIM follow-up group also showed that only 12% of the participants needed 100 therapy hours or less. This study confirms that longer periods of therapy are necessary and helpful for women suffering from Complex PTSD. This is consistent with Gold et al.'s (2009) study looking at dose-effect of music therapy for patients with severe mental illness. They found that with 3-10 sessions only small effect sizes are achieved, while large effect sizes are seen after 16-51 sessions. Also in this study large effect sizes are achieved after 50 therapy hours; however, it appears that patients with Complex PTSD usually have therapy times of more than 100 therapy hours, most probably to solidify the results

of their therapies. Nothing can be said about the other factors listed above from this study.

After having discussed the negative and protective factors after traumatization, I proceed with the helpful and hindering therapeutic attitudes and behaviors. The findings from prior research on this topic are reported in 2.2.2. The importance of *communicating about the therapeutic relationship* in trauma therapy was not mentioned in any of the literature discussed in 2.2.2, but Pain et al. (2010) suggest talking about the patient's fears of the therapeutic relationship which – as it is an unequal relationship – might remind the patient of the perpetrator-victim-relationship. This corresponds with my own reflections on the nature of the therapeutic relationship. It is widely stressed in the literature on trauma therapy that *mutually and creatively looking for solutions of problems* is helpful for survivors (Harper et al., 2008; Pain et al., 2010; Steele et al., 2001; van der Hart et al., 2006). This includes problems in the patient's life as well as problems in the structure of the therapy and the therapeutic relationship. Also the concept of *clarity and transparency from the therapist* in order to make a therapeutic relationship possible that is safe for the survivor is reported in the literature. Both in this study in the literature on trauma therapy it is mentioned that in the past survivors experienced unsafe and unpredictable relationships. To be able to feel some safety in the therapeutic relationship – which is the prerequisite for deeper therapeutic work – clarity and transparency from the therapist are necessary (Harper et al., 2008; Pain et al., 2010; Steele et al., 2001; van der Hart et al., 2006). *Acknowledging the trauma and its effects* as well as *taking the side of the survivor* and the dangers that arise if this is not done were already reported in the literature in 2.2.2 (Birck, 2001; Fischer & Riedesser, 1999). Ambivalence about the therapeutic relationship is frequently seen in trauma therapy. *Being able to stay with the patient's pressure and ambivalence towards the therapeutic relationship* is reported as helpful by the participants of this study, but also by the participants of Birck's (2001) study. The fact that *the therapist should keep confidentiality* about contents of therapy is part of every code of ethics for psychotherapy and in many countries also regulated by laws. The impor-

tance of *discussing problems of everyday life with the therapist* is not mentioned in the studies reviewed in 2.2.2, but can be found in the newer literature. The participating trauma survivors of Harper et al.'s (2008) study reported that as helpful. Loewenstein and Welzant (2010) even put more emphasis on it. They held that therapy is impossible if the basic life and health needs are not met, and stated that these needs should be discussed in the very beginning of therapy. When it comes to termination of therapy *knowing one can come back to the therapist for new therapy* is stressed as helpful and even necessary (but widely ignored by health insurances and health policy makers) not only by the participants of this study, but also in the trauma therapy literature (see for example Herman, 1992; Steele et al., 2001; van der Hart et al., 2006). Steele et al. (2001) suggested a maintenance therapy for trauma survivors who completed therapy. If the survivor wants it, he or she should be able to come to his or her therapist for an hour about once a month or every other month for as long as the survivor wants to. The goal of this maintenance therapy is to maintain the effects of therapy and to prevent relapse. The following helpful attitudes and behaviors of therapists from this study were not mentioned in other studies or literature on trauma therapy:

1. The therapist admits if s/he does not know something, which should lead to shared reflection on the problem.
2. The therapist should care of him-/herself both as model, and so that the patient does not feel like she has to do it. This is discussed in the general literature regarding supervision, therapy training, secondary traumatization etc. as important for the health of the therapist, but it is not mentioned as equally important for the health of the patients.
3. The therapist as outside observer. This is a basic function of the therapist in any kind of therapy, but in the trauma therapy research literature it was not mentioned by any participant as helpful.

After discussing the helpful therapeutic attitudes and behaviors, we now come to the hindering attitudes and behaviors. In Birck's (2001) study described in 2.2.2, her re-

search participants described the following therapeutic attitudes and behaviors as hindering:

1. The therapist tries to avoid, minimize the effects of, or doubts the sexual abuse.
2. A neutral attitude of the therapist towards the violence, or silence as response to accounts of abuse can be frightening.
3. Having to lie down or not being able to see the therapist in the therapy session (for example if the therapist is sitting behind the client's head) can be frightening for clients.
4. Not acknowledging the ambivalence felt by the clients.
5. Trying to get to the core of the traumas before the therapeutic relationship is stable enough.
6. Not allowing the client the right to withdraw or change the topic if feelings or memories become overwhelming.
7. Asking the client to empathize with the perpetrator.

Numbers 1, 2 and 4 are also mentioned by participants from this study. Number 3 is mentioned by one participant from this study who had difficulties lying down in analysis but not in GIM. Traditional Psychoanalysis is today seen as contraindicated for traumatized patients, because it does not give enough structure and safety to the patient which usually is destabilizing (see for example Fischer & Riedesser 1999). Maybe the reason for not being able to lie down can be rather found in the therapy method and in the attitude of the therapist rather than in the lying down itself. Numbers 5-7 were not mentioned by participants from this study. This might be due to the fact that Birck's participants most probably had their therapies in the 90s or earlier in Germany and Austria. At that time knowledge about trauma and trauma therapy was not widely spread in the therapeutic communities of these countries. If I look from my own perspective as a trauma survivor, I would consider the therapeutic behaviors 5-7 as hindering for me, too, and I am glad that I never experienced them.

Steele et al. (2001) and Wilson and Lindy (1999) list obstructing countertransference reactions (see Figure 2.1 and Table 2.1). They divide these countertransference reactions into “enmeshed” and “distanced”. Some of the hindering therapeutic attitudes and behaviors reported by participants from this study fall under these categories. They are displayed in Table 5.2.

Table 5.2: Enmeshed and Distanced Therapeutic Attitudes and Behaviors

Enmeshed	Distanced
Power-games, power-struggles	Power-games, power-struggles
Overly protective therapists	Accusations (dissociation or fear is used for manipulation, etc.)
Unreflected dual relationships, abusive dual relationships	The therapist did not say much. It made the participant feel left alone and unsure of what to do or say.
	The therapist did not believe the trauma stories of the participant.

These attitudes and behaviors can be seen as obstructing countertransference reactions which can be found explicitly or implicitly in Figure 2.1 and Table 2.1. The hindering therapeutic attitudes and behaviors that are added to the literature by the participants of this study are:

1. Mindless interventions (for example “Stop dissociating!”).
2. The therapist underestimates the importance of him-/herself in therapy.
3. The therapist was too esoteric and not grounded enough. This was reported as confusing and lacking clarity and a base in reality.
4. The therapist sat directly opposite to the participant. This setup gave the participant no choices of where to look.
5. Having to leave a session feeling “upside down.”
6. Not being able to clarify difficulties with the therapist. The reasons for that may be in the therapist or in the participant.

Neither the participants who had experienced PITT nor those who had experienced GIM could say much about how they experienced their therapists as different during the

time imagery was used vs. the time imagery was not used in therapy. I explored some of it in my own reflections (see 4.2.2.3). When I was in a more regressed state in the ASC, I experienced my therapist as similar to a parent. In the GIM literature this is confirmed and further elaborated using Stern's theory of the infant's development of the Self (Geiger 2007, Geiger & Maack 2010). Some of this literature is reviewed in 2.3.5. When I was in a transpersonal state in the ASC, the therapist felt more like a witness. During the music listening period, I always perceived the therapist's attitude in a stronger way and more directly than in the pre- or post-session processing.

5.2.3.2 Theory of PITT

The basic theories of PITT are described in 2.4. This chapter is reviewed to discuss this study in relation to the basic theories. This study confirms that nurturing and protecting resources can be developed through the use of PITT in trauma therapy which then helps the patients to calm themselves down, cope with overwhelming emotions and feelings, and learn to better care for themselves (Reddemann, 2003; 2004; 2006). This again most probably helps to decrease acting-out behavior as stated by Reddemann (2003). Even though the participants of this study did not explicitly talk about acting out behavior, it can be assumed that it decreases when patients are better able to calm themselves down, to cope with overwhelming feelings and emotions, and to care for themselves in a better way.

Some parts of the theory of PITT described in 2.4 are in opposition to the findings from this study. These are the areas of the body and leading interventions. While work with the body is described in Reddemann (2003), interview partners had the feeling that the body was left out of their therapies. They wanted body work to be integrated into their therapies. This most probably depends on the therapist. The PITT training is very short. If the therapist had no training in a body-centered psychotherapy or in the use of bodywork in trauma therapy, they would not be able to integrate this into trauma therapy with PITT. According to PITT-theory, therapists should lead as little as possible but instead accompany, inform, and encourage the patient rather than instruct her of what exactly to do or to see

(Reddemann, 2004). My interview partners found that the therapists were leading the imagery too much, and that they gave too specific pictures of what they should or should not imagine.

Another piece of PITT theory could neither be confirmed nor was it in opposition with the findings of this study: Reddemann (2004; 2006) sees the value of working with imagery in PITT as trying out things before doing them in real life, and as creating new ways of being or new possibilities in a safe and creative way. None of my interview partners reported that they did that. But as I only interviewed five persons it does not mean that it never happens.

In the last part of this section we come to the parts of PITT theory that were reconfirmed by the one interview partner who experienced PITT according to Reddemann's (2004) manual, but they were contrary to the experiences of the interview partners who listened to standardized imagery scripts or CDs during their therapy sessions. These areas were:

1. The patient learns to explore different parts of herself, who then can communicate with each other and with the therapist (Reddemann, 2003; 2004).
2. Imagery is used in the therapeutic dialogue (Reddemann, 2004).
3. The therapist asks the patient open questions about her imagery (for example "How does it look like?" or "What does it need to feel safe?"; Reddemann, 2004).
4. Traumatized patients can reconstruct their inner systems through the use of imagery (Reddemann, 2004; 2006).

It seems to be necessary for the future that the PITT community decides whether they want the use of imagery CDs and imagery scripts in trauma therapy to be called PITT or not. At the moment it appears like in the PITT literature the use of scripts and CDs is not mentioned, but clinicians frequently use it and call it PITT. This might create problems for PITT research and also for communication about PITT among colleagues or with patients, especially if the researcher or therapist does not know about these undifferentiated two kinds of PITT.

5.2.3.3 Imagery in GIM and its Adaptations in Trauma Therapy

Körlin (2002) described a process of symbolization in GIM that is helpful for traumatized patients. His theory is briefly outlined in 2.3.7. Körlin (2002) states, that symbolization of traumatic events is most of the time missing or incomplete in traumatized patients. He then describes the symbolization processes of traumatized patients seen in GIM sessions. His accounts are from the therapist perspective informed by neuroscience. His theory is reconfirmed by statements of participants from this study when reflecting on their own inner processes during GIM therapy. The categories of *imagery as form* and *imagery as connector* can serve as depictions of Körlin's (2002) theory of symbolization.

The use of imagery in GIM in general is described in 2.3.4. None of the findings from this study is in opposition to the general theory of imagery in GIM. But while the theories described in 2.3.4 look at the use and the levels of imagery in GIM from the outside, this study is rather concerned with the meaning of imagery for the individual traumatized patient. Therefore additional theories are needed to discuss the findings. The additional theories discussed here are theory of metaphor – especially metaphors in psychotherapy – and neuroscience. Metaphor is defined as “understanding and experiencing one kind of thing in terms of another” (Lankoff & Johnson, 1980, p. 5). Metaphors in psychotherapy

1. represent unconscious fantasies, elements, and structures of the patient.
2. combine the abstract and the concrete.
3. connect verbal and nonverbal experiences as well as the conscious and the unconscious and by that may play an essential role in the therapeutic process of change.
4. emphasize and hide: not all aspects of meaning are disclosed and supported.
5. make verbal expression of and communication about experiences possible that cannot be expressed otherwise.
6. connect language with tacit, experienced knowledge of the patient.
7. Metaphors in communication enhance empathy and contact in the therapeutic relationship.

(Bonde, 2005; Geiger & Maack, 2010; Siegelmann, 1990)

In this study, inner structures of the patient become visible through imagery. This can especially be found in the category of *imagery as form*. Inner parts of the participants and their relationships with each other show themselves in the imagery and can be changed through it. In this example, the abstract and the concrete are combined. The abstract inner psychic structures become inner parts in relationship. The participants put their tacit knowledge (of the inner structures) into a concrete form which can be expressed in language. The pure inner psychic structures could not be expressed in language. Using the metaphorical way of communicating them (for example as inner parts) is the only way for the participants to express them to their therapists. Only then can they be understood and the therapist can empathize with the participant. Imagery is not just offering a form here, but it is also used as *a way of speaking*. Other faces of *imagery as a way of speaking* are discussed in the next paragraph.

Participants used *imagery as a way of speaking*. This helped them especially to go around the prohibition to speak about the traumatic experiences, and to deal with the fear of the therapist not believing what had happened to them. Also here the abstract and the concrete are combined. Participants talk about a concrete experience in an abstract form which emphasizes some things – especially the feelings of the participants – and hides others, namely the exact facts of the experience. If the prohibition to speak about traumatic experiences is still strong, talking about the exact facts most probably would trigger flashbacks. Speaking in metaphors about it makes communication about it possible without getting into flashbacks which again enhances empathy in the therapeutic relationship.

Imagery as a resource in everyday life and *imagery as a way of coping with trauma* are similar in some ways. Resource imagery for example helped participants to calm down when they were in flashbacks. Here the abstract imagery is used to reach concrete everyday goals.

Imagery as a connector was mentioned by many participants. Connecting the verbal and the nonverbal, the conscious and the unconscious, and language with tacit knowledge are examples also directly or indirectly mentioned by the participants.

Imagery as space between client and therapist both emphasizes and hides the transference at the same time: It shows the contents of the transference without disclosing to the therapist directly that it is transference or that the imagery is about the therapist.

One category of roles of imagery mentioned by the participants that is not covered by theory of metaphor in psychotherapy is *imagery for learning*. Leuner and Wilke (2011) mentioned that imagery allows for practicing things before doing them in the outside world in Guided Affective Imagery¹⁶, which has many similarities with GIM. Reddemann (2004; 2006) stressed the value of imagery in PITT in this area (see 2.4.2). From the neurosciences we know that if we imagine something the same areas of the brain become active as if we really do that thing (see for example Bauer, 2006; Hüther, 2004c).

The neuroscientist Siegel (2007) described image formation and its meaning for memory and for reflective thinking. When we take in a sensation or sensations we create images that then are deposited into long-term memory. There they are categorized and classified into descriptive forms. The more image categories we have in our long-term memory, the easier it becomes to accomplish tasks quasi automatically. This can be helpful – for example when driving a car – or hindering. Traumatized persons have many inner images, for example of the inner structure, that create difficult situations for the traumatized person. For example, if I am faced with a threatening situation, an inner child might come to the foreground that used to deal with similar situations in the past by freezing. But as an adult it might be better to just leave this situation instead of freeze. Reflective thinking and with that restructuring some of the older inner structures might help to transform this.

Reflective thinking is information processing that manipulates images, not descriptions. ... Reflective thinking occurs when what is stored in long-term memory is not sufficient to allow one to accomplish a task directly. ... Reflective thinking ... would

¹⁶ Guided Affective Imagery may be practiced with or without music (Leuner 1974).

enable a more fluid state to be achieved as the stream of thoughts flow through consciousness and are not locked in to any one particular prior classification. Sensing novelty may require that we turn toward images, not word-based categories. (Siegel, 2007, pp. 249 ff)

Examples of this can be found in the descriptions of participants of this study who for example used imagery to make inner structures visible and transform them, as well as by those who used imagery for learning.

5.2.3.4 Music in GIM and its Adaptations in Trauma Therapy

The basic theory of the use and the roles of music in GIM and its adaptations are outlined in 2.3.3. One of the functions of music in GIM is to evoke imagery (Bruscia, 2002a; Bush & Stokes, 1999; Goldberg, 1992; 2002; Grocke, 2002a). This widely recognized role of music in GIM is reconfirmed by the participants of this study. Other roles of music that are reconfirmed by this study are “music as space” (Grocke, 2002a; Summer, 1995), “music as teacher, as keeper of knowledge and abilities” (Bruscia, 2002a; Bush & Stokes, 1999; Isenberg-Grzeda, 1999), “music as helper” (Bush & Stokes, 1999), and “music as keeper” (Bush & Stokes, 1999). These areas appear to be general ones and not specific to traumatized patients. None of the roles of music found in this study is in opposition to general theory about the use of music in GIM, but I consider two additional theoretical backgrounds as important for explaining the results of this study. They are Kohut’s concept of selfobject (Geiger & Maack, 2010; Sand & Levin, 1992; von der Stein, 2007) and Stern’s (2010a) concept of forms of vitality.

A selfobject is another (real or virtual) person with whom a child has to be in vivid communication, so that the child can develop. It serves the child to regulate the self, including affects and emotions and to complete his inner structures and skills. Selfobjects are perceived by the child as more or less part of himself. Adults still need selfobjects. If the early development was successful selfobjects for adults are not seen as fused anymore (von der Stein, 2007). Persons with Complex PTSD often had insufficient or disrupted sel-

fobjects. The core symptom of Complex PTSD is affect dysregulation (see 2.1). Good selfobjects are necessary for making some normal development possible through therapy that was not possible during childhood due to traumatizations. In psychotherapy usually the therapist serves as selfobject. However, the therapist is not always available and sometimes refuses to fulfill certain needs of the patient. Music on the other hand can be present for the patient as much as she needs it, and it does not object if the patient only understands it out of her own needs. The following categories of roles of music from this study suggest the use of music as selfobject by participants:

1. Music as teacher, as keeper of knowledge or abilities
2. Music as relationships
3. Music as space
4. Music as keeper
5. Music as helper
6. Music as beauty, as connector with non-violent parts of the world

It is not necessarily obvious what the aspect of space has to do with selfobjects. Both music and selfobjects are perceived as space or environments (Sand & Levin, 1992; von der Stein, 2007). Von der Stein (2007) called the selfobject a matrix, fertile soil, or topsoil for self development. “Ein gesundes Selbstobjektmilieu ist unaufdringlich im Hintergrund präsent, wie Luft oder wie Wasser zum physischen Überleben nötig ist.”¹⁷ (von der Stein, 2007, p. 123) When music becomes a selfobject, the listener makes the music – which first is an object – her own, understands music out of her very personal needs, and gives it her own meaning. By that, the listener can form and create the object music, and at the same time makes it possible for the music to represent back to the listener what she needs at a certain time (Buhrmester, 2008; Geiger & Maack, 2010).

Next we come to Stern’s (2010a) concept of forms of vitality. Forms of vitality are changing happenings consisting of movement, force, space, intention, and time. These happenings can be almost anything, for example thoughts, movements, emotions, interac-

¹⁷ Translation: “A healthy selfobject milieu is discreetly present in the background similar to air or water which is necessary for bodily survival.”

tions, etc. The concept of forms of vitality rather deals with the contours of these happenings than with its contexts. (Stern, 2010a; 2010b) When we look at vitality forms of traumatic events, there usually is an attack followed by sudden high arousal which stays until the perceived threat is gone – sometimes a few seconds, sometimes days or months – or until the threatened person is so exhausted that she collapses. Once the perceived threat is gone, there usually is a sudden hyperarousal of the parasympathetic nervous system because of exhaustion. Later, whenever flashbacks appear, they take the same shape. Persons who lived through prolonged traumatizations during childhood mainly experienced these forms of vitality, which are helpful in the face of threat, but hindering in almost everything else in everyday life. Music offers diverse forms of vitality which are not content-bound. With the help of music and its forms of vitality, traumatized persons can expand their repertoire of forms of vitality. The forms of vitality in music might help traumatized persons to calm themselves down, to be in relationship in more consistent ways, and to modulate affect. The forms of vitality in the music might also remind patients of experiences, inner parts, or even universal knowledge or archetypes that have similar forms of vitality and by that evoke imagery, which then are shaped and maybe manipulated also by the vitality forms of the music (see also neurobiological theory of reflective thinking outlined in 5.2.3.3). The following roles of music from this study would correspond with the concept of forms of vitality:

1. Music as teacher, as keeper of knowledge or abilities
2. Music as relationships
3. Music as representative of dissociated parts
4. Music as keeper
5. Music as bringer or evoker of imagery, music as vehicle into imagery
6. Music as helper
7. Music as beauty, as connector with non-violent parts of the world.

5.2.3.5 Adaptations of GIM in Trauma Therapy

In this study, not only the pure and original form of the Bonny Method of GIM was used, but also adaptations. These adaptations are described in 2.3.2 and 3.1.2. Information about which adaptations were used and when in this study was not collected. Therapists were free to use GIM adaptations or GIM in its original form as indicated. However, there was a hint to the necessity of using adaptations from M, one of the interview partners. She was in the follow-up group and had her GIM therapy ten years before the interview. At that time GIM adaptations were not used very much, and most probably were not used in her therapy, either. She reported that when the music was longer than 20-30 minutes, it would bring up too much psychic material to be covered in the post-session processing. If that happened it made her feel “upside down” after the session. Most of the GIM adaptations are shorter and / or more focused versions of the original Bonny Method. I think that for traumatized patients the original Bonny Methods most often is contraindicated in the beginning of their therapies. Here adaptations are necessary. Also when the intensity level of flashbacks and trauma reactions rises during therapy, adaptations would be the method of choice. Later in therapy and with less intense flashbacks and trauma reactions, GIM in its original form might be very beneficial. In Table 5.3 I give an overview over intensity levels of flashbacks and trauma reactions as described by the Traumaprojekt Hamburg (2012) and possible uses of GIM and its adaptations that would be indicated at that level according to my experience.

Table 5.3: Indication of GIM and its Adaptations at Different Levels of Flashback and Trauma Reaction Intensity

Intensity Level	Indication
0: No trauma reactions	GIM
1: Trauma reactions are hidden and often appear as character traits. Life is organized around possible triggers, but as they are known and avoided, trauma reactions are not overt.	GIM, Music and Imagery
2: Clear but manageable trauma reactions like light sudden fear, nausea, dissociation, etc. The survivor usually knows these symptoms already for many years, and she knows how to handle them. These reactions often appear “normal” to the survivor.	GIM, Contained Spontaneous Imaging
3: Acute panic which is obvious and can be quite disturbing. The survivor feels threatened and reacts to it psychologically and physically. The survivor is aware of these reactions. At this level the usual coping mechanisms (are about to) fail.	Music Breathing, Contained Spontaneous Imaging
4: Severe trauma reactions alternate with calmer periods as in Borderline Personality Disorder. Different more or less dissociated inner parts may appear on the surface as for example in dissociative disorders. Self mutilating behavior or open aggression against others may be seen at this level.	Music Breathing, Contained Spontaneous Imaging
5: Acute brief psychotic episodes appear after severe triggers. The surrounding of the survivor usually is not supportive. The survivor might be weakened through alcohol, drugs, or psychological distress.	Music Breathing

GIM = The Bonny Method of Guided Imagery and Music

I put Music and Imagery at Level 1; however, I hardly ever use Music and Imagery as a therapist with traumatized patients because the patient does not speak which means I might miss severe flashbacks, dissociative states or other trauma reactions. I only use it in trauma therapy if for other reasons the patient is unable to use any of the other adaptations listed in Table 5.3. If Music Breathing is possible at Level 5, it usually is very helpful. However, when trauma reactions are so strong, often it is not possible to use Music Breathing anymore, because the patient is not approachable anymore.

What I discussed in this part mainly stems from my own experience as a traumatized patient in GIM therapy and as a trauma therapist using GIM and adaptations. This area needs further research.

5.3 Limitations

5.3.1 Limitations Inherent in the Research Design

The study focuses only on the client perspective. In the quantitative part, only patients of trauma therapy answered the questionnaires. In the qualitative part, Moustakas' Heuristic Research is used, which offers reflective and highly subjective data. It covers Wilber's (1996) areas of the interior-individual and the interior-collective or cultural, but leaves out the exterior-individual and the exterior-collective or social. To give a fuller picture of trauma, trauma survivors, and trauma therapy, it would need other studies that focus for example on behavior observations of participants, information from significant others of traumatized persons or from therapists, physiological measurements, etc. to complete the picture.

The study is also limited to adult women. It would need more research to see if the results are also true for men or – in an adapted way – for children or adolescents.

Another limitation is that PITT most probably in many cases was not conducted according to Reddemann's (2004) manual even though the therapists were instructed to do so. It would be interesting to see how results would differ if free, spontaneous, and individualized imagery without music was used in trauma therapy with a similar population.

5.3.2 The Researcher's Own Therapy Allegiances

I described my own background and beliefs about GIM and PITT before starting the data collection in 3.3.4. When I conducted the interviews, I noticed that there were two kinds of PITT: One was described in Chapters 2 and 3. The other one is using taped imagery exercises or pre-formulated scripts of imagery exercises in verbal psychotherapy – usually in psychodynamic or cognitive behavioral psychotherapy. The latter I would not have chosen as a comparison to GIM and its modifications, because it is too different. I also do not believe that using standardized imagery scripts (read or in recorded form) would be

a particularly helpful intervention in the therapy sessions. My own allegiance to GIM might have influenced the outcome.

Luborsky et al. (1999) found a strong correlation between the researcher's treatment allegiances with outcomes of those treatments when comparing treatment methods. They were looking only at empirical research. The authors suggest the following reasons for this:

1. The author may compare his favorite treatment to a treatment that he knows to be less effective in general or with the chosen population.
2. The author might not publish the study if the outcome was not supportive of the author's favored treatment.
3. The skillfulness of the selected therapists might differ.
4. The therapists chosen to take part in the study by the author may do better than usual because they want the study to have good results.

As mentioned in Section 3.3.4, I did not expect PITT to be less effective than GIM, so reason 1 is not in place in this study. Reason 2 does not apply. A doctoral dissertation has to be published no matter what the results are. It cannot be said whether the skillfulness of the selected therapists in the area of trauma therapy differed. However, it is likely that skillfulness in the use of GIM and PITT differed: Four of the nine GIM therapists who took part in the study are also primary trainers for the method, while none of the PITT therapists in the study was a trainer for PITT. Reason 4 may be present, but there is no possibility to confirm or reject this statement using the data of this study.

Luborsky et al. (1999) also gave recommendations for how to minimize the influence of researcher's allegiance:

1. Include different researchers in the team who have different therapy allegiances.
2. Correct the results for the impact of researcher's allegiance.
3. Have therapists selected and supervised by those who respect the treatment.
4. The researchers should have minimal differences in allegiance to the treatments compared.

In our team, which consists of my doctoral supervisors and me, three of the four researchers had strong positive allegiances to GIM. My doctoral supervisors did not know PITT, so there were neither positive nor negative allegiances to it. I asked GIM therapists to take part in the study, while Luise Reddemann – the founder of PITT – asked PITT-therapists to take part in the study, so Recommendation 3 was fulfilled.

I expect my own positive allegiance to GIM to have more influence on the qualitative part of the study than on the quantitative part. Especially when I found out in the interviews that CDs or pre-formulated scripts were used, I noticed that my sympathy for PITT lessened. This may show in Chapter 4.2.4 and in Chapter 5.

5.3.3 Differences in the Participants' Nationalities

The PITT group, the GIM treatment group, and the control group did not match in the area of nationalities of participants (see 4.1.2.1). Which nationalities were present in each group, are displayed in Table 4.2. The main differences between the groups were:

1. In the GIM group there were about 60% US Americans while in the PITT and in the control group there were no US Americans.
2. In the PITT and in the control group there were more than 80% Germans, while in the GIM group there were only about 25% Germans.
3. There were about 15% Swedes in the GIM group and about 15% Swiss in the PITT group. The rest of the nationalities present in the groups were less than 10% each.

Common areas in which cultural differences are found are (a) individualism vs. collectivism, (b) high-power difference vs. low-power difference, (c) high-uncertainty avoidance vs. low-uncertainty avoidance, and (d) masculinity vs. femininity¹⁸ (see for example Draguns, 1997). Hofstede and Bond (1988) compared 52 countries in these areas, among them the United States, Germany, Sweden, and Switzerland. Their study showed that in the area of power distance the four countries are very similar but not in the other areas. In the area of

¹⁸ Femininity is associated with caring and nurturing, and masculinity with coping and assertiveness.

individualism vs. collectivism, the United States scored higher in individualism than the other three countries, which are similar to each other. Sweden has a much higher score on femininity than the other three countries which, again, are similar to each other. In the area of uncertainty avoidance all four countries score quite differently from each other with Germany having the highest score of uncertainty avoidance followed by Switzerland, then the United States, and finally Sweden with the least uncertainty avoidance. Looking at Hofstede and Bond's study, we see that the PITT group and the control group are not very different in terms of cultural differences in the four areas, but the GIM group differs from the other two groups. Participants from the GIM group most probably would score higher in individualism, lower on uncertainty avoidance, and higher on femininity than the participants from the other groups if they were tested.

Draguns (1997) described what these cultural dimensions would mean for therapeutical interventions with PTSD. Table 5.3 gives an overview.

Table 5.4: Cultural Dimensions and Psychotherapy for PTSD

Collectivism: Alleviation of suffering Relationship problems, shame Therapist as nurturing mother Social integration Acceptance of controls Harmonious relationships	Individualism: Insight, self-understanding Guilt, alienation, loneliness Therapist as father figure Development of individuality Development of responsibility Interpersonal conflict and its resolution
High-Uncertainty Avoidance: Biological explanations Behavioral techniques Medical orientation Tightly regulated therapy practice	Low-Uncertainty Avoidance: Psychological explanations Experiential psychotherapy Multiprofessional orientation Loosely regulated therapy practice
Masculinity: Prosocial orientation Responsibility, conformity, adjustment Guilt Enabling	Femininity: Prosocial orientation Expressiveness, creativity, empathy Anxiety Caring

From: Draguns (1997), p. 475

As a next step, I looked at GIM and PITT to see in which of the areas described by Draguns are their strengths and weaknesses. GIM would be useful both in individualistic and in collectivistic cultures. For collectivistic cultures, however, group psychotherapy might

be better than individual psychotherapy. The attitude of the therapist in this area seems more important than the features of GIM as therapy method. But the fact that the therapists came from the same countries and had the same nationalities as the participants would control for this variable. GIM would be more suitable in cultures with low-uncertainty avoidance and for cultures where femininity is stronger as it goes well with the experiential orientation, the loosely regulated therapy practice, and with the expressiveness and creativity inherent in the method.

With PITT we have the problem that it was either done according to Reddemann's (2004) manual or using standardized scripts or CDs. These two ways of practice fall into slightly different areas. PITT with standardized scripts or CDs falls more on the left side of Table 5.3. If PITT was done according to the manual, it would be useful in both individualistic and collectivistic cultures. Similar to GIM, I would suggest group work in collectivistic cultures. In the area of uncertainty avoidance and masculinity vs. femininity, PITT according to the manual would lean more towards the left side of Table 5.3, but not as much as PITT with standardized scripts or CDs.

If we consider all this, it appears like both the GIM and the PITT group got what culturally would serve them better. The control group with mainly German participants, however, suffered by not being treated maybe more than if they came from a more individualistic culture: alleviation of suffering, social integration, and a need for harmonious relationships were not offered. A nurturing other in form of a therapist was withheld. By not acknowledging their hurt through withholding treatment, feelings of shame might become stronger. The area of uncertainty avoidance most probably was not important for the control group, but with higher masculinity, participants from the control group might suffer more from not being able to adjust to society and from not being able to be responsible for themselves for example in terms of work or private life.

In summary, it can be said that the PITT group and the control group were matching well enough in terms of nationality and cultural differences. Cultural differences appear most prominent between the GIM and the control group, but are also important between the

GIM and the PITT group. This might have influenced the results of the quantitative part somewhat.

5.3.4 Moustakas' Heuristic Research

The qualitative part of the study used Moustakas' method of Heuristic Research. This implies that the researcher includes her own experiences of the phenomenon as data into the study. Interview situations with research participants have an atmosphere in which two persons speak about a shared experience. I am a trauma survivor who suffered from Complex PTSD, and I was a patient in GIM therapy. But I was never a patient in PITT therapy. This compromised my subjective knowledge of PITT, which had an influence on the interview situations. With participants who had experienced GIM therapy I was able to speak in a different, more informed and more subjective way than with participants who had experienced PITT therapy. If I had only studied PITT, Moustakas' Heuristic Research would not have been my research method of choice. I was briefly considering going into PITT therapy before I did the interviews, but I rejected this idea because I would have gone into PITT therapy because of the study and not – like my interview partners – because I was seeking therapy. So even if I had gone into PITT therapy for the study, it would have been a very different situation than a real therapy situation. I would consider my reflections on PITT in the qualitative part less valid from a subjective point of view than my reflections on GIM. I have the feeling with PITT that I am more of an informed outside observer, while with GIM I can speak from my own experience.

5.4 Applications of the Findings

5.4.1 Clinical Applications

Results from the quantitative part of the study are very promising suggesting that GIM and its adaptations should definitely be used in the treatment of women with Complex PTSD. They also suggest that GIM brings something into the treatment of Complex PTSD

that most probably other kinds of treatment do not have, maybe the music or the music in combination with imagery, but it may also be the ASC, the openness and space inherent in the method¹⁹, or the special kind of therapeutic relationship that is created during the music listening period. What exactly makes this huge change in outcome still awaits further research. It is important, though, that the GIM therapists who use the method with patients with Complex PTSD are well trained psychotherapists who had training and supervision in trauma therapy and who have worked on their own traumatizations in personal therapy – either with GIM or other methods used in trauma therapy. Otherwise therapists are prone to act out disturbing countertransference reactions as described in 2.2.2 or show hindering therapeutic attitudes and behaviors as described in 4.2.4.3. It is also important that therapists using GIM with persons with Complex PTSD have good intellectual and felt knowledge of the nature of the therapeutic relationship and the rule of abstinence. This seems to be obvious; however, two of the participants commented about unethical behavior by GIM therapists which suggests that these therapists either did not have this knowledge or did not work enough on their own traumatizations to be good enough therapists.

The qualitative part of this study suggests that PITT has better results and is better received and understood by patients when it is done according to Reddemann's (2004) manual compared to reading imagery scripts or listening to CDs. It might also have a better therapy outcome, but that cannot be seen from the quantitative part, as the two ways of doing PITT were not differentiated there.

5.4.2 Implications for GIM Training

As the results of this study are very promising for the use of GIM for women with Complex PTSD, and as many psychiatric disorders seem to have their origin in prolonged traumatization (see for example Janssen et al., 2005; Read, van Os, Morrison, & Ross, 2005; Traumaprojekt Hamburg, 2012; van der Hart, Nijenhuis, & Steele, 2006), ample

¹⁹ Traumatic situations narrow the focus down to just the threat while GIM widens the awareness and therefore might be perceived as less similar to trauma and therefore less threatening.

training in treating patients with Complex PTSD with GIM and its adaptations should be included into the general GIM training. I would suggest that it should not only be part of the course work, but also of supervision and personal sessions.

Training should include thorough teaching of the nature of the therapeutic relationship – especially on the rule of abstinence – during the courses and in supervision. Trainers, supervisors, and therapists doing personal sessions with GIM trainees should not only teach but also model it. Two of the five participants of the qualitative part of the study who experienced GIM reported difficulties in this area. Using the concepts of music as selfobject and Stern's (2010a) forms of vitality as theoretical background (see 5.2.3.4) in GIM training, could enrich students' understanding of the use of music in GIM and its adaptations.

5.4.3 Applications for PITT Training

I am not a PITT therapist or trainer. Therefore I feel hesitant to name any applications for PITT training. Maybe the main applications and implications for PITT training from this study – if there are any – have to be found by experts in the field of PITT. One of the questions that should be clarified within the PITT community is: Do they want PITT to be done according to Reddemann's (2004) manual, or do they want to include reading preformulated imagery scripts or listening to imagery CDs during the therapy session as part of PITT? If everything should be included, there may be no implications from this study for PITT training. If PITT should be done according to Reddemann's (2004) manual, I would suggest not to give out imagery scripts during the training – except maybe one exemplary and very individualized script together with the case description – and to include individual supervision and personal therapy with PITT in the training requirements.

5.5 Directions for Future Research

The results from the quantitative part of the study are very much in favor of GIM and its adaptations in trauma therapy for patients with Complex PTSD. It would be good to

replicate this part of the study to reconfirm or to question the results. It would be good if the experimental group and the control group were equivalent in the area of nationalities of the participants than in this study.

As this study focused on the client perspective, further studies using GIM or PITT with patients with Complex PTSD focusing on the therapist perspective, on the perspective of objective observers, or on physiological measurements would help to complete the picture. The therapist is the best source for information about psychodynamics and personality structure. Objective observers best describe simple behavior counts, performance on clinically relevant objective criteria (for example self-mutilating behavior), and for perceived interaction patterns (Bond et al., 1979, Fiske 1975, Greenberg & Pinsof 1986, Gurman & Kinskern 1981). Physiological measurements might show stress levels or changes in the brain (for example of the size of the hippocampus).

Research question 3 b – Are there limitations in the use of music in trauma therapy for women with Complex PTSD? – could not be answered through this study. The possible reasons for that were outlined in 5.1.2. I still think that this is an important question. It may be better answered by asking trauma therapists who are trained in GIM when they use GIM or its adaptations with patients and when they do not and why. This could be done again with Moustakas' Heuristic Research design, but this time from the therapists' perspective.

It would be interesting to see if the roles of music and imagery in GIM and the helping and hindering attitudes and behaviors of the therapist would be generalizable to GIM in general or if they are specific to GIM in trauma therapy, or only to women but not men or children and adolescents. Research with nontraumatized populations, as well as with men, children, and adolescents looking at these areas could further clarify this.

And finally further research on the basic psychological structures of Complex PTSD within the psyche could help to further enhance trauma therapy in general. Most of the knowledge we have about Complex PTSD is derived from research on Simple PTSD. I believe, however, that there are major differences between the two disorders which would

also lead to different ways of therapy. The Traumaprojekt Hamburg (2012) suggested that in Complex PTSD, the main problem for a patient with Complex PTSD is a number of perpetrator introjects in the superegos of different ego states of the traumatized person that need to be “given back” to the perpetrators and then be replaced with healthy identifications. This might eliminate the source of further flashbacks. A complete description of the basic theory of this is beyond the scope of this thesis. However, I consider further research in this area as well as looking at GIM in relation to these newly emerging theories as promising further areas of research.

5.6 Conclusion

This study examined the influence of PITT and GIM and its adaptations in individual outpatient trauma therapy with women with Complex PTSD from the client perspective. A mixed methods design was used to look at outcome of 50 hours of trauma therapy with PITT or with GIM and its adaptations compared to a wait list control group on symptoms of Complex PTSD, dissociation, interpersonal problems, and factors promoting health in a quantitative investigation; and explore the roles of music in GIM and of imagery and the therapeutic relationship in GIM and PITT in trauma therapy using Moustakas’ (1990) Heuristic Research in a qualitative investigation. A few studies have previously documented a decrease of some individual symptoms of Complex PTSD and dissociation through the use of GIM and PITT for traumatized patients; however, this was the first controlled outcome study of individual outpatient trauma therapy using these methods, as well as the first study looking at music, imagery, and the therapeutic relationship in trauma therapy with GIM and PITT from the client perspective.

Going back to the research questions, the following summarizing statements can be made:

Is GIM, PITT, or both of these methods indicated for severely traumatized women?

Participants from the GIM treatment group and the PITT group improved significantly compared to the participants from the control group whose health condition measured by the selected variables worsened. Participants from the GIM treatment group improved significantly more than participants from the PITT group. The results from this study suggest that both PITT and GIM and its adaptations are indicated for severely traumatized women, but GIM would be the treatment of choice.

When would GIM and when would PITT be indicated?

As GIM and its adaptations had significantly better results than PITT in this study, usually GIM would be indicated. PITT – as currently practiced – would be sufficient if the focus of the therapeutic work would be limited to finding and strengthening resources and to calming oneself.

What are different roles of music in imagery-based trauma therapy? What could music be particularly helpful with?

Roles of music and areas in which music can be particularly helpful with as reported by participants of this study are:

1. Music as teacher, as keeper of knowledge or abilities
2. Music as relationships
3. Music as space
4. Music as representative of dissociated parts
5. Music as keeper
6. Music as bringer or evoker of imagery, music as vehicle into imagery
7. Music as helper
8. Music as beauty, as connector with nonviolent parts of the world

Are there limitations in the use of music?

This question cannot be answered through this study. The results suggest that there are no limitations. However, from my own experience as a clinician I know that for some traumatized patients music can be too much at times or in general. As this usually becomes clear during the first 2-3 sessions, most probably these patients were not taken into the study.

What are characteristics of the treatment of women with Complex PTSD?

The therapist should be well educated, have good knowledge about (Complex) PTSD and about the therapeutic relationship, especially about the rule of abstinence, and create a holding, caring, careful, supportive atmosphere. Clarity and transparency are important to make the traumatized patient feel safe enough for therapeutic work which should as much as possible have an atmosphere of mutuality with as little power difference as possible. The therapist should not try to take a neutral position towards the violence experienced by the patient, but should clearly position himself on the side of the survivor. Therapists should also model good self-care. It is important that the therapist neither gets enmeshed with the patient and her life nor tries to make too much distance. Both would just be an acting-out of the therapist's own trauma story and making the necessary empathy impossible. Moreover, when traumatized persons seek therapy, they should not have to wait for it, and they should get as much therapy with the same therapist as is necessary for healing and maintaining a healthy condition.

The study indicated that both GIM and PITT have the potential to significantly improve symptoms of Complex PTSD and dissociation, alleviate interpersonal problems, and enhance factors that promote health in severely traumatized women. GIM and its adaptations were significantly more helpful than PITT. This may be due to the use of music and / or to the more individualized practice of GIM. Music in imagery-based trauma therapy can be used as self-object, and it also offers forms of vitality that may be used by traumatized patients for healing.

ENGLISH SUMMARY

Introduction

The aim of this study was to find out which roles music could play in imagery-based trauma therapy. Therefore the outcome of the Bonny Method of Guided Imagery and Music (GIM) and its adaptations was compared to Psychodynamic Imaginative Trauma Therapy (PITT) as developed and described by Reddemann (2004) for women with Complex Post Traumatic Stress Disorder (PTSD) with or without comorbidity. GIM and PITT are very similar. One big difference, however, is the use of recorded music in GIM. The study focuses on the client perspective. The researcher brings in her own experiences as patient in trauma therapy in the qualitative part of this study, but not in the quantitative part.

Psychological trauma is defined in the DSM-IV (American Psychiatric Association, 1994) as

1. "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2. the person's response involved intense fear, helplessness, or horror."

(American Psychiatric Association, 1994, p. 209)

Fischer and Riedesser (1999) define it in a more conflict-oriented way as "a vital experience of discrepancy between threatening factors of the situation and the individual possibilities for coping with accompanying feelings of helplessness and abandonment without protection, which in turn permanently shakes the view of self and the world" (Fischer & Riedesser, 1999, p. 351, my translation).

Complex PTSD was first described by Herman (1998). Her model concentrated on multiple traumatizations over a prolonged period of time and its consequences for the victim. It included some areas that are not included in PTSD, such as dissociative experiences, interpersonal difficulties, and loss of basic assumptions (Hansen, 1999). The

diagnosis of Complex PTSD is neither included in the DSM-IV (1994), the DSM-V (in print), nor in the ICD-10 (1993); however discussions of how to include trauma-related disorders in the diagnostic manuals are still ongoing (see for example Luxenburg et al., 2001).

Herman (1998) describes the need for this diagnosis:

In general, the diagnostic categories of the existing psychiatric canon are simply not designed for survivors of extreme situations and do not fit them well. The persistent anxiety, phobias, and panic of survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not the same as ordinary psychosomatic disorders. Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder. ... Even the diagnosis of "post-traumatic stress disorder", as it is presently defined, does not fit accurately enough. ... Survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity. Survivors of abuse in childhood develop similar problems with relationships and identity; in addition, they are particularly vulnerable to repeated harm, both self-inflicted and at the hands of others. (Herman 1998, p. 118 f)

The symptoms of Complex PTSD include alterations in affect regulation, alterations in consciousness, alterations in self-perception, alterations in relations with others, somatization, and alterations in systems of meaning.

In general, 40-60% of all persons are traumatized at least once in their lives. About 25% of them develop (Complex) PTSD. (Breslau et al., 1998; Kessler et al, 1995; Seidler, 2002) Comorbidity is seen in 80-90% of patients with (Complex) PTSD (Kessler et al., 1995; Craemer et al., 2001).

GIM is defined as a

music-centered exploration of consciousness. It offers persons the opportunity to integrate mental, emotional, physical, and spiritual aspects of well-being, as well as

awaken to a greater transcendent identity. It is practiced primarily in psychotherapy and counseling settings. Specially sequenced classical music programs are used to stimulate and sustain a dynamic unfolding of inner experiences. (AMI, 1990)

In this study, adaptations of GIM for traumatized patients or for patients with only limited ego-strength are used along with the traditional form. GIM and its adaptations can help traumatized patients with “transformation of traumatic imagery into symbolic imagery, establishment of cognitive memory and understanding, and integrating the resulting discursive symbols with analogic symbol and affect.” (Körlin, 2002, p. 406) Other outcomes described in the literature are: finding and trying out resources (Körlin, 2002; Pickett, 1992; Pickett & Sonnen, 1993), increased self-esteem (Blake, 1994; Körlin, 2002; Pickett, 1992), getting in touch with and working through feelings and emotions (Blake, 1994; Tasney, 1993), greater sense of hope, increased relaxation, decreased hypervigilance (Blake & Bishop, 1994), reduction of intrusive thoughts (Blake & Bishop, 1994; Körlin, 2002), anger control, decreased addiction (Pickett, 1995), and decreased numbing (Körlin, 2002).

PITT is based on analytical objects relations theory, ego psychology, the use of perception of transference and countertransference, and the concept of ego states as described by Watkins and Watkins (1997). It uses a 3-phase model of stabilization, trauma confrontation, and integration as described by Herman (1998), working with imagery in a process-oriented way. Similar to GIM, it stresses self-regulation and self-healing; both methods are, among others, working with images of the body (Reddemann, 2003; Summer, 1990). PITT helps patients to decrease acting-out behavior, symptoms of depression and dissociation, the use of primitive defense mechanisms, and avoidance behavior, to feel more empowered, and to improve self-soothing (Lampe et al., 2008; Sachse et al., 2006; Reddemann, 2003).

The use of GIM and its adaptations and PITT in trauma therapy is quite similar. The main difference is the use of music in GIM but not in PITT.

Research Questions

Comparing GIM and PITT might contribute to clarifying the following questions:

1. Is GIM, PITT, or both of these methods indicated for severely traumatized adult patients?
2. When would GIM and when would PITT be indicated?
3. What are different roles of music in imagery-based trauma therapy?
 - a) What could music be particularly helpful with?
 - b) Are there limitations in the use of music?
4. What are characteristics of the treatment of patients with Complex PTSD?

Research questions 1 and 2 were answered through the empirical outcome study.

Research questions 3, and 4 were answered by the qualitative interview study.

Methodology

The study is a mixed-methods design divided into a quantitative and a qualitative part. The quantitative part is a comparative outcome study of the two imagery-based methods of trauma-therapy: PITT and GIM and its adaptations. The study is based on the premise that both methods are indicated as treatment for women with Complex PTSD. However, it was hoped that different results in the different questionnaires used or in its subscales may point to areas in which music may be more or less helpful in their therapies.

In the qualitative part, heuristic research was used to find out about the meaning of music, imagery and the therapeutic relationship in trauma therapy for the research participants. The whole study took place in a naturalistic setting.

Quantitative Study

To answer research questions 1 and 2, a controlled trial was designed including three conditions and a separate but matched follow-up group to check if results were stable over time:

1. Patients treated with individual outpatient psychotherapy using GIM or its adaptations;
2. Patients treated with individual outpatient psychotherapy using PITT;
3. Patients on a waiting list for individual outpatient psychotherapy.
4. Separate but matched follow-up group: Patients who had been in individual outpatient psychotherapy using GIM or its adaptations, but finished therapy at least one year before filling in the questionnaires. During their therapy, they had at least 16 therapy-hours of GIM or its adaptations.

Participants from the groups 1 and 2 received 50 hours of outpatient trauma therapy. In at least 16 of the 50 therapy hours, GIM or PITT was used. Participants from the control group waited at least nine months for their therapy.

There were 34 participants in each group. Participants completed a battery of questionnaires. Participants from group 1 and 2 filled in questionnaires after the first 3-5 therapy sessions, after 25 therapy hours, and after 50 therapy hours. Participants from the control group filled in questionnaires in the beginning and at the end of their waiting time, and participants from the follow-up group filled in questionnaires only once.

Research participants were 136 female adult patients suffering from Complex PTSD with or without co-morbidity due to prolonged interpersonal traumatization. Patients with psychosis, mental disorders due to a general medical condition, cognitive disorders, or patients who at the beginning of treatment were actively abusing substances were not included in the study. Another exclusion criterion was a pending lawsuit against any of the perpetrators at the beginning of treatment.

GIM therapists included in the study as clinicians had finished formal GIM training, had at least a bachelor's degree in the clinical mental health field or an international equivalent, and had experience working with severely traumatized patients as primary psychotherapists. PITT therapists were licensed psychotherapists or counselors and held at least a bachelor's degree in the clinical mental health field or an international equivalent. The PITT therapists were asked to conduct therapy according to Reddemann's (2004)

manual. They did not use music in their treatment. The GIM therapists were asked to conduct therapy as described in Bonny (2002) and Bruscia and Grocke (2002). The researcher was not one of the participating therapists.

Measurements used in the study were:

1. The Self-Report Inventory for Disorders of Extreme Stress (SIDES-SR) by van der Kolk (2002; main outcome). It measures symptoms of Complex PTSD. It was used as a diagnostic instrument, as well as an instrument for measuring progress in therapy.
2. The Dissociative Experience Scale-Taxon (DES-T) by Waller, Putnam and Carlson (1996) measures symptoms of structural dissociation.
3. The Somatization Dissociation Questionnaire (SDQ-5) by Nijenhuis et al. (1996) measuring dissociation in the body.
4. The Inventory of Interpersonal Problems for Personality Disorders (IIP-PD25) by Kim and Pilkonis (1999).
5. The short version of the Sense of Coherence Scale (SOC) by Antonovsky (1987) measures factors that promote improvement of health.

Qualitative Study

Heuristic research as described by Moustakas (1990) was applied to answer research questions 2, 3, and 4. This is a kind of reflective research in which the researcher herself is one of the research participants. (Bruscia, 2005; Moustakas, 1990). Heuristic research

starts with formulating the research questions and defining its primary terms and meanings. After that, methods ... are open-ended. They point to a process of accomplishing something in a thoughtful and orderly way that guides the researcher. There is no exclusive list that would be appropriate for every heuristic investigation, but rather each research process unfolds in its own way. (Moustakas, 1990, p. 43)

However, the author described six phases of heuristic research. They are (a) initial engagement, (b) immersion, (c) incubation, (d) illumination, (e) explication, and (f) creative synthesis. These phases guide the thought process of the researcher, her way of being with the research topic or a detail of it, and even her attitude towards the research process itself. Moustakas (1990) gave the following guidelines for data-analysis:

1. Gathering all data from one research participant.
2. Entering into the material in timeless immersion until it is understood both as a whole and in its details.
3. A period of incubation follows. Then the material is reviewed again and the researcher takes notes, identifying the qualities and themes manifested in the data. This enables the researcher to write an individual depiction of the experience. The individual depiction includes qualities and themes of the experience, and examples from the interview are given.
4. Returning to the original data of the participant and checking if the individual depiction fits the original data, and if it contains all important qualities and themes. If not, revising the individual depiction. Sharing the individual depiction with the research participant for affirmation of comprehensiveness and accuracy and for suggested deletions and additions.
5. The same steps are taken for every other individual research participant.
6. Immersion into all individual depictions with intervals of incubation until the universal qualities and themes of the experience are understood. Writing a composite depiction that represents the common qualities and themes of the experience including examples from the data material.
7. Returning to the raw data of all participants and the individual depictions, the researcher chooses two or three participants who exemplify the group as a whole. The researcher develops individual portraits of these participants.

Before interviewing any research participants, I reflected on my own experiences with music, imagery, and the therapeutic relationship in my personal trauma therapy with

GIM. Then I chose four participants who experienced GIM in their therapies, and five who experienced PITT from the pool of participants of the quantitative study. These participants took part in semi-structured interviews about their experiences with music (GIM only), imagery, and the therapeutic relationship in their therapies. The data were analyzed as described above.

Results

Results from the Quantitative Analysis

The results revealed significantly greater improvement in symptoms of Complex PTSD, dissociation, and quality of life, as well as significantly less interpersonal problems for both the GIM treatment group and the PITT group as compared to the control group. In addition participants from the GIM follow-up group had similar scores as the GIM treatment group at posttest in the areas of dissociation, interpersonal problems, and quality of life. This suggests that results in these areas may be stable over time. Symptoms of Complex PTSD scored significantly lower in the GIM follow-up group than in the GIM treatment group at posttest. This suggests that more treatment than 50 therapy hours could further reduce symptoms of Complex PTSD, and this reduction, too, might be stable over time after termination of therapy, or that those who receive GIM might continue to improve over time. Both GIM and PITT are indicated for severely traumatized women.

The results in addition revealed significantly greater improvement in symptoms of Complex PTSD, dissociation, and quality of life, as well as significantly greater reduction of interpersonal problems for participants of the GIM treatment group as compared to the PITT group. Effect size could be measured for the two dissociation scales and for the SOC. The effect size for GIM was very large on all measurements when comparing pretest to posttest, while the effect size of PITT was small to medium for the DES-T and the SOC. On the SDQ-5, PITT had a small negative effect size. This suggests that treatment with GIM and its modifications may be superior to treatment with PITT for severely traumatized

women in all areas measured in this study. This might be especially true for patients with somatoform dissociation.

Results from the Qualitative Analysis

From the interviews with the participants who had experienced PITT, it became clear that many PITT-therapists did not conduct PITT according to Reddemann's manual. Instead of using free, individualized imagery, they either read standardized imagery scripts from Reddemann or other PITT-therapists, or they used imagery CDs during the session.

Research participants who had experienced GIM described eight functions and roles of music:

1. Music as teacher, as keeper of knowledge or abilities
2. Music as relationships
3. Music as space
4. Music as representative of dissociated parts
5. Music as keeper
6. Music as bringer or evoker of imagery, music as vehicle into imagery
7. Music as helper
8. Music as beauty, as connector with non-violent parts of the world

Participants who had experienced GIM also described eight functions and roles of imagery in their therapies:

1. Imagery as a way of speaking
2. Imagery for learning
3. Imagery as a way of coping with trauma
4. Imagery as form
5. Imagery as space between client and therapist
6. Imagery as connector
7. Imagery as resource in everyday life
8. Imagery as a help to focus

Only functions number 2, 6, and 7 were also described by participants who had experienced PITT. Only one of the five participants had experienced PITT according to Reddemann's manual. She also described imagery as making inner life visible (= imagery as form). While some GIM participants were afraid of what working with imagery might bring up for them, all finally found imagery very helpful, and with the help of the music could master the fear. The PITT participants who listened to imagery scripts or an imagery CD saw imagery as an exercise that had to be done right, and for some there was fear of not being able to do so. They also said that they did not understand the purpose of imagery in their therapy sessions. While all the GIM participants and the one PITT participant who experienced PITT according to Reddemann's manual found imagery an essential part of their therapy, and they could not have gotten where they were without it, the other PITT participants said that it would not have made any difference if imagery had not been used in their therapies.

Participants from both groups reported the following therapeutic attitudes and behaviors as helpful:

1. Communication about the therapeutic relationship
2. Mutually and creatively looking for solutions of problems
3. Clarity and transparency from therapist
4. The therapist admits if s/he does not know something, which should lead to shared reflection on the problem
5. Holding, caring, careful, supportive attitude
6. The therapist should care of him-/herself both as model, and so that the patient does not feel like she has to do it
7. Acknowledging the trauma and its effects
8. Taking the side of the survivor (taking a neutral position towards violence means taking the side of the perpetrator)
9. Being able to stay with the patient's pressure and ambivalence towards the therapeutic relationship

10. The therapist keeps confidentiality.
11. The therapist as outside observer.
12. The therapist is supportive with problems of everyday life.
13. Knowing one can come back to the therapist for new therapy after termination.

The following attitudes and behaviors of therapists were seen as hindering by participants of both groups:

1. Overly protective therapists
2. Power-games, power-struggles.
3. Unreflected dual relationships, abusive dual relationships.
4. Mindless interventions (for example "Stop dissociating!").
5. Accusations (dissociation or fear is used for manipulation, etc.).
6. The therapist underestimates the importance of him-/herself in therapy.
7. The therapist did not say much. It made the participants feels left alone and unsure of what to do or say.
8. The therapist was too esoteric and not grounded enough. This was reported as confusing and lacking clarity and a base in reality.
9. The therapist sat directly opposite to the participant. This setup gave the participant no choices of where to look.
10. Lying down in analysis. It is interesting to note that the participant could not lie down in analysis but had no problems lying down in GIM. She did not know why that was so.
11. The therapist did not believe the trauma stories of the participant.
12. Longer periods of therapist's vacation or absence from work.
13. Having to leave a session feeling "upside down."
14. Not being able to clarify difficulties with the therapist. The reasons for that may be in the therapist or in the participant.

Discussion

The significant improvement on measures of symptoms of trauma-related disorders between GIM and the control group and between PITT and the control group were congruent with other studies using GIM or PITT for trauma survivors. The significantly greater improvement of participants receiving GIM compared to PITT was a surprise. This in part, however, might be due to the fact that most probably PITT was not used according to Reddemann's manual. If imagery in PITT had been used in a freer and more individualized way, the results might be better.

From the qualitative part of the study it could be seen that imagery can be used for learning, as connector, and as resource for coping with trauma in everyday life both in GIM and in PITT. However, in PITT the focus in these areas is strictly on calming oneself and on resources while in GIM the focus is broader. In GIM imagery is used as form, as space between patient and therapist, as a way of speaking, and as a help to focus. The functions of imagery as a resource in everyday life and as a way of speaking have no parallel in the roles of music. It needs imagery to fulfill these functions.

On the other hand, there are roles that only music has. These are music as relationship, music as keeper, and music as bringer and evoker of imagery. In addition there are roles that both imagery and music have in GIM, but they are somewhat complementary. Both imagery and music can be used for learning, but while music is like the teacher who models things, imagery offers the possibility for trying these things out. Both imagery and music can be used as form, but while imagery is a very concrete form, music is a rather abstract form, maybe more a suggestion of form. The same is true for music and imagery as connectors: Imagery portrays clear connections while music gives abstract and indirect suggestions for connections. Both music and imagery can be perceived as space. Here it is the other way round: music is the more concrete space where many things are possible. It offers space for imagery to take form. Imagery also is a space, but in a more abstract and hidden way. It mainly gives space for the expression of transference. The same is true for music and imagery as helper. Music can be per-

ceived as a third person in the therapy room that is actively helping the patient. Imagery is more of an indirect and abstract helper for focusing, and for keeping with the story and the issues at hand.

The use of music seems to significantly enhance imagery-based trauma therapy. The theories of music as self-object, that is, Kohut's (1984) Self Psychology, as well as Stern's theory of forms of vitality (Stern, 2010a) can be drawn upon as theoretical backgrounds.

Symptoms of the participants from the control group significantly worsened through the long period of waiting. People with Complex PTSD might compensate for a while if there are no important changes in their lives, and as long as they are still strong enough. If they are faced with more triggers, and therefore more flashbacks, they might seek therapy. If help is withheld at these times, their condition might worsen. The fact that they were not helped again might also be a new trigger, which might bring up more flashbacks in addition to the already existing ones.

Limitations of the study are my own treatment allegiance; the fact that participants groups did not match in the area of participants' nationalities; and that I never experienced PITT myself, and therefore I could use the heuristic protocol only for GIM but not accurately for PITT. The study is also limited to the client perspective and to female patients.

It would be good to replicate the empirical part of the study with a more homogeneous sample in terms of nationalities of participants and a team of researchers who have allegiances to all treatment methods represented in the study. A corresponding study with men might show whether there are gender differences or not. Further research would also be necessary for finding out more about the impact of waiting for therapy, and about when and for which kind of traumatized patients the use of music in therapy would not be helpful. And finally more basic research for building theories about trauma itself, hopefully leading to causal treatment of trauma are necessary.

Conclusion

The study indicated that both GIM and PITT have the potential to significantly improve symptoms of Complex PTSD and dissociation, alleviate interpersonal problems, and enhance factors that promote health in severely traumatized women. GIM and its adaptations were significantly more helpful than PITT. This may be due to the use of music and / or to the more individualized practice of GIM. Music in imagery-based trauma therapy can be used as self-object, and it also offers forms of vitality that may be used by traumatized patients for healing.

DANSK RESUMÉ

Formålet med denne undersøgelse var at finde ud af, hvilke roller musik kan spille i traume-terapi baseret på arbejde med indre forestillingsbilleder (imagery). Derfor sammenlignes resultatet af Guided Imagery and Music (GIM - Bonny Metoden) og denne metodes forskellige modifikationer med resultatet af Psykodynamisk Imaginativ Traume-Terapi (PITT), som er udviklet og beskrevet af Reddemann (2004) for kvinder med kompleks Post Traumatisk Stress Disorder (PTSD), med eller uden komorbiditet. GIM og PITT er meget ens. En stor forskel er dog brugen af indspillet (klasisk) musik i GIM. Undersøgelsen fokuserer på klientens perspektiv. Forskeren inkluderer egne oplevelser som patient i traume-terapi i den kvalitative del af undersøgelsen, men ikke i den kvantitative del.

Psyriske traumer er defineret i DSM-IV (American Psychiatric Association 1994) som

1. "Personen oplevede, var vidne til eller blev konfronteret med en begivenhed eller hændelser, der involverede faktisk eller truende død eller alvorlig skade, eller en trussel mod egen eller andres fysiske integritet
2. personens svar involverede intens frygt, hjælpeløshed eller rædsel."

(American Psychiatric Association 1994, s. 209)

Fischer & Riedesser (1999) definerer det på en mere konflikt-orienteret måde som "en afgørende oplevelse af uoverensstemmelse mellem truende faktorer i en situation og de individuelle muligheder for at håndtere ledsagende følelser af hjælpeløshed og forladthed uden beskyttelse, hvilket permanent ryster oplevelsen af selv og verden." (Fischer & Riedesser 1999, s. 351)

Kompleks PTSD blev først beskrevet af Herman (1998). Hendes model koncentrerer sig om flere traumatiserende episoder over en længere periode og deres konsekvenser for

offeret. Det omfatter nogle områder, der ikke indgår i PTSD, såsom dissociative oplevelser og interpersonelle vanskeligheder, og tab af grundlæggende antagelser (Hansen, 1999). Diagnosen Komplex PTSD indgår hverken i DSM-IV (1994), eller i ICD-10 (1993), dog diskuteres det fortsat hvordan man kan inddrage traume-relaterede lidelser i de diagnostiske manualer (se for eksempel Luxenburg et al. 2001). Herman (1998) beskriver behovet for denne diagnose:

"Generelt er de diagnostiske kategorier i den eksisterende psykiatriske kanon simpelthen ikke beregnet til overlevende i ekstreme situationer og passer ikke godt til dem. Den vedvarende angst, fobier og panik hos de overlevende er ikke det samme som almindelige angstlidelser. De somatiske symptomer hos de overlevende er ikke det samme som almindelige psykosomatiske lidelser. Deres depression er ikke det samme som almindelig depression. Og nedbrydningen af deres identitet og relationelle liv er ikke det samme som almindelig personlighedsforstyrrelse. ... Selv diagnosticering af "post-traumatisk stress disorder", som det i øjeblikket er defineret, passer ikke præcist nok De overlevende udvikler efter længere tids misbrug karakteristiske personlighedsændringer, herunder deformationer af relationsevne og identitet. De som har overlevet misbrug i barndommen udvikler lignende problemer med relationer og identitet, desuden er de særligt sårbare over for gentagne skader, uanset om de er påført af andre eller dem selv." (Herman 1998, s. 118 f.).

Symptomerne på kompleks PTSD omfatter ændringer i affektregulering, ændringer i bevidsthed, ændringer i selvopfattelse, ændringer i relationer, somatisering, og ændringer i meningssystemer.

Generelt bliver 40-60% af alle personer traumatiseret mindst én gang i deres liv. Ca. 25% af dem udvikler (kompleks) PTSD (Breslau et al. 1998, Kessler et al 1995, Seidler 2002). Komorbiditet ses i 80-90% af patienterne med (kompleks) PTSD (Kessler et al. 1995 Craemer et al. 2001).

GIM defineres som en "musik-centreret udforskning af bevidstheden. Dette giver personer mulighed for at integrere mentale, følelsesmæssige, fysiske og åndelige aspekter af tilværelsen, samt for at vågne op til en mere transcendent identitet. Metoden praktiseres primært i psykoterapi og rådgivning. Specielt tilrettelagte klassiske musikprogrammer bruges til at stimulere og fastholde en dynamisk udfoldelse af indre oplevelser." (AMI, 1990) I nærværende undersøgelser anvendes modificeringer af GIM specielt rettet mod traumatiserede patienter eller patienter med begrænset ego-styrke sammen med den traditionelle form (Bonny-metoden). GIM og modificeret GIM kan hjælpe traumatiserede patienter med "transformation af traumatisk billedsprog til symbolsk billedsprog, etablering af kognitiv hukommelse og forståelse, og integrering af de nye diskursive symboler med analoge symboler og affekter." (Körlin, 2002, s. 406) Andre effekter, som er beskrevet i litteraturen, er: at finde og afprøve ressourcer (Körlin, 2002; Pickett, 1992; Pickett & Sonnen, 1993), øget selvværd (Blake, 1994; Körlin, 2002; Pickett, 1992), at komme i kontakt med og gennemarbejde følelser og emotioner (Blake, 1994; Tasney, 1993), at skabe større følelse af håb, øget afspænding, nedsat hypervagtsomhed (Blake & Bishop, 1994), reduktion af forstyrrende tanker (Blake & Bishop, 1994; Körlin, 2002), vredeskontrol, nedsat afhængighed (Pickett, 1995), og reduceret følelsesløshed (Körlin, 2002).

PITT er baseret på analytisk objektrelationsteori, ego-psykologi, brugen af overføring og modoverføring, og begrebet ego-tilstande som beskrevet af Watkins & Watkins (1997). Der anvendes en 3-faset model: stabilisering, traume-konfrontation og integration, som beskrevet af Herman (1998), og der arbejdes med indre billeder på en proces-orienteret måde. Ligesom i GIM lægges der vægt på selv-regulering og selv-healing, og begge metoder arbejder med krops-billeder (Reddemann, 2003, Sommer, 1990). PITT hjælper patienter til reduktion af a) udadagerende adfærd (acting-out), b) symptomer på depression og dissociation, c) brugen af primitive forsvarsmekanismer og d) undgåelsesadfærd, og

med at fremme følelsen af selvstændighed, og forbedre evnen til selv-lindring (Lampe et al 2008, Sachse et al. 2006, Reddemann 2003).

Brugen af GIM inkl. modifikationer og PITT i traumer terapi er temmelig ens. Den væsentligste forskel er brugen af musik i GIM, men ikke i PITT.

Forskningsspørgsmål

En sammenligning af GIM og PITT vil kunne bidrage til at afklare følgende spørgsmål:

1. Er GIM, PITT eller begge metoder indikeret for stærkt traumatiserede voksne patienter?
2. Hvornår vil GIM, og hvornår vil PITT være en indikeret behandlingsform?
3. Hvad er musikkens forskellige roller i billeddannelses-baseret traumeterapi? a) Hvad kan musikken være særlig behjælpelig med? b) Er der begrænsninger i brugen af musik?
4. Hvad er karakteristisk for behandlingen af patienter med kompleks PTSD?

Forskningsspørgsmålene 1 og 2 blev besvaret gennem den empiriske effektundersøgelse.

Forskningsspørgsmålene 1, 3 og 4 blev besvaret gennem den kvalitative interviewundersøgelse.

Metode

Der er tale om et undersøgelsesdesign med blandede metoder, opdelt i en kvantitativ og en kvalitativ del. Den kvantitative del er en komparativ effektundersøgelse af de to billeddannelses-baserede traumebehandlingsmetoder PITT og GIM inkl. modifikationer. Undersøgelsen er baseret på den præmis, at begge metoder er indikerede som behandlingsform til kvinder med kompleks PTSD. Det var dog forskerens håb, at forskellige resultater i de anvendte spørgeskemaer eller i deres underskalaer kunne pege på områder, hvor musikken kan være mere eller mindre nyttig i behandlingen af disse kvinder.

I den kvalitative del blev en heuristisk forskningsmetode anvendt til at undersøge betydningen af musik, indre billeder og den terapeutiske relation i deltagernes traumeterapi. Hele undersøgelsen fandt sted i en naturalistisk setting.

Den kvantitative undersøgelse

For at besvare forskningsspørgsmål 1 og 2 tilrettelagdes en kontrolleret effektundersøgelse med tre forsøgsbetingelser og en separat, men matchende follow-up gruppe for at undersøge om eventuelle effekter ville være stabile over tid :

1. Patienter i individuel ambulant psykoterapi blev behandlet med GIM eller modificeret GIM;
2. Patienter i individuel ambulant psykoterapi blev behandlet med PITT;
3. Kontrolgruppe: Patienter på venteliste til individuel ambulant psykoterapi.
4. En separat men matchende follow-up-gruppe: Patienter, som havde været i individuel ambulant psykoterapi med GIM eller modificeret GIM, men afsluttet terapien mindst et år før udfyldning af spørgeskemaerne. Deltagerne havde fået mindst 16 timers terapi med GIM eller modificeret GIM.

Deltagerne i grupperne 1 og 2 gennemgik 50 timers ambulant traumeterapi. I mindst 16 af disse 50 terapitimer blev enten GIM eller PITT anvendt. Deltagere i kontrolgruppen ventede mindst ni måneder på behandling.

Der var 34 deltagere i hver gruppe, og alle udfyldte et batteri af spørgeskemaer. Deltagere i gruppe 1 og 2 udfyldte spørgeskemaerne a) efter de første 3-5 terapisessioner, b) efter 25 terapitimer, og c) efter 50 terapitimer. Deltagere i kontrolgruppen udfyldte spørgeskemaerne i begyndelsen og slutningen af deres ventetid, mens deltagere i follow-up-gruppen kun udfyldte spørgeskemaerne én gang.

Forskningsdeltagerne var kvindelige voksne patienter med kompleks PTSD med eller uden co-morbiditet som følge af langvarig interpersonel traumatisering ($n = 136$). Patienter med psykoser, mentale forstyrrelser på grund af en generel medicinsk tilstand, kognitive

lidelser, eller patienter, som ved starten af behandlingen var aktive misbrugere af stoffer blev ikke inkluderet i undersøgelsen. Et andet udelukkelses-kriterium var en verserende retssag mod en gerningsmand ved behandlingens begyndelse.

De GIM-terapeuter, der medvirkede i undersøgelsen, var klinikere med en afsluttet formel GIM-uddannelse, og mindst en bachelorgrad inden for det psykiatriske område, eller noget internationalt tilsvarende, og alle havde erfaring med at arbejde med alvorligt traumatiserede patienter som primær psykoterapeut. PITT-terapeuterne var alle autoriserede psykoterapeuter eller rådgivere med mindst en bachelorgrad inden for det psykiatriske område, eller noget tilsvarende. PITT-terapeuterne blev bedt om at udføre behandlingen i henhold til Reddemanns (2004) manual. De brugte ikke musik i behandlingen. GIM-terapeuterne blev bedt om at udføre terapien efter de retningslinjer, som er beskrevet i Bonny (2002) og Bruscia & Grocke (2002). Forskeren var ikke en af de deltagende terapeuter.

De måleredskaber, der blev brugt i undersøgelsen, var:

1. Spørgeskemaet The Self-Report Inventory for Disorders of Extreme Stress (SIDES-SR) af van der Kolk (2002) (Hovedeffektmål). SIDES-SR måler symptomer ved kompleks PTSD. Det blev anvendt både som diagnostisk instrument og til måling af fremskridt i terapien.
2. The Dissociative Experience Scale-Taxon (DES-T) af Waller, Putnam & Carlsson (1996) måler symptomer på strukturel dissociation.
3. The Somatization Dissociation Questionnaire (SDQ-5) af Nijenhuis, van der Hart & Van derlinden (1996) måler dissociationer i kroppen.
4. The Inventory of Interpersonal Problems for Personality Disorders (IIP-PD25) af Kim & Pilkonis (1999).
5. Den korte udgave af Antonovskys Sense of Coherence Scale (SOC) (1987) måler faktorer, der fremmer forbedring af sundheden.

Den kvalitative undersøgelse

Heuristisk forskning som beskrevet af Moustakas (1990) blev anvendt til at besvare forskningsspørgsmål 1, 3 og 4. Der er tale om en form for reflekterende forskning, hvor forskeren selv er forskningsdeltager (Bruscia 2005, Moustakas 1990). En heuristisk undersøgelse begynder med at formulere forskningsspørgsmålene og definere dens vigtigste begreber og betydningssammenhænge. Derefter er metoderne åbne og uden fast slutpunkt. De peger mod en proces hvor det givne emne undersøges på en refleksiv og velordnet måde, der guider forskeren. Der er ingen komplet liste, der passer til enhver heuristisk undersøgelse; hver forskningsproces udfolder sig på sin egen måde. (Moustakas 1990, s. 43). Men forfatteren beskriver seks faser i heuristisk forskning: a) indledende engagement, b) fordybelse, c) inkubation, d) illumination, e) eksplicitering og f) kreativ syntese. Disse faser guider forskerens tankeproces, hendes måde at engagere sig i forskningsemnet eller en detalje af det på, og endda hendes holdning til selve forskningsprocessen. Moustakas (1990) opstiller følgende retningslinjer for dataanalysen:

1. Indsamling af alle data fra én forskningsdeltager.
2. Fordybelse i materialet over lang tid, indtil det forstås både som en helhed og i alle detaljer.
3. Herefter følger en inkubationsperiode. Materialet gennemgås igen, og forskeren tager notater og identificerer de kvaliteter og temaer, der kommer til udtryk i data. Dette gør det muligt for forskeren at skrive en individuel skildring (depiction) af oplevelsen. Denne individuelle skildring omfatter oplevelsens væsentlige kvaliteter og temaer af oplevelsen, og der gives eksempler fra interviewet med den pågældende deltager.
4. Forskeren vender nu tilbage til de oprindelige data og kontrollerer, at den individuelle skildringen passer med disse, og om alle væsentlige kvaliteter og temaer er medtaget. Hvis ikke revideres skildringen. Forskeren deler derefter

skildringen med den pågældende forskningsdeltager mhp bekræftelse af skildringens alsidighed og nøjagtighed og evt. behov for sletninger og tilføjelser.

5. De samme skridt tages for hver enkelt af de øvrige forskningsdeltagere.
6. Forskeren fordyber sig i alle individuelle skildringer i inkubationsperioder, indtil de universelle kvaliteter og temaer ved oplevelsen er forstået. Herefter skrives en sammensat skildring, der repræsenterer oplevelsens fælles kvaliteter og temaer, med eksempler fra datamaterialet.
7. Forskeren vender herefter tilbage til rådata fra alle deltagere og til de individuelle skildringer, og udvælger på baggrund heraf to eller tre deltagere, der eksemplificerer gruppen som helhed. Forskeren udvikler individuelle portrætter af disse deltagere.

Før interviewene med forskningsdeltagerne reflekterede jeg over mine egne oplevelser med musik, indre billeder, og de terapeutiske relationer i min egen personlige traumebehandling med GIM. Så valgte jeg fra puljen af samtlige deltagere i den kvantitative undersøgelse fire deltagere, der oplevede GIM i deres terapi, og fem der oplevede PITT. Disse 9 deltog i semi-strukturerede interviews om deres oplevelser med musik (kun GIM-deltagerne), indre billeder, og den terapeutiske relation i deres terapiforløb. Data blev analyseret som beskrevet ovenfor.

Resultater

Resultaterne af den kvantitative analyse

Resultaterne viste signifikant større forbedring i symptomer på Komplex PTSD, dissociation, og livskvalitet, samt signifikant større reduktion af interpersonelle problemer for både GIM behandlingsgruppen og PITT gruppen sammenlignet med kontrolgruppen. Desuden havde deltagerne fra GIM follow-up-gruppen samme score som GIM behandlingsgruppen ved post-test inden for dissociation, interpersonelle problemer og livskvalitet. Dette tyder på, at resultaterne i disse områder kan være stabil over tid.

Symptomer på Komplex PTSD blev scoreet signifikant lavere i GIM opfølgingsgruppen end i GIM behandlingsgruppen ved post-test. Dette tyder på, at mere behandling end 50 terapitimer ville kunne reducere symptomer på Komplex PTSD yderligere, og at denne reduktion også kan være stabil over tid efter afslutning af behandlingen. Både GIM og PITT er således indikerede behandlingsformer for svært traumatiserede kvinder.

Resultaterne derudover viste signifikant større forbedring i symptomer på Komplex PTSD, dissociation, og livskvalitet, samt signifikant større reduktion af interpersonelle problemer for deltagerne i GIM behandlingsgruppen sammenlignet med PITT gruppen. Effektstørrelse kunne måles for de to dissociationsskalaer og for SOC. Effektstørrelsen for GIM var meget stor i alle målinger som sammenlignede præ-test med post-test, mens effektstørrelsen for PITT var lille til medium for DES-T og SOC. På SDQ-5 havde PITT en lille negativ effektstørrelse. Dette tyder på, at behandling med GIM inklusive modifikationer kan være bedre end behandling med PITT til alvorligt traumatiserede på alle målområder i denne undersøgelse. Dette kan især gælde for patienter med somatoform dissociation.

Resultater af den kvalitative analyse

Fra interviews med de deltagere, som havde oplevet PITT, blev det klart, at mange PITT-terapeuter ikke udførte PITT i overensstemmelse med Reddemanns manual. I stedet for at bruge fri, individualiseret billeddannelse oplæste de enten standardiserede billeddannelsesmanuskripter af Reddemann eller andre PITT-terapeuter, eller de brugte CD'er med billeddannelsesinstruktion under sessionen.

Forskningsdeltagere fra GIM gruppen beskrev otte funktioner og roller, som musik kan have:

1. Musik som lærer, som indehaver af viden eller evner
2. Musik som relationer
3. Musik som rum
4. Musik som repræsentant for dissocierede dele
5. Musik som beholder

6. Musik som fremkalder af billeder, musik som en vej ind til billeder
7. Musik som hjælper
8. Musik som skønhed, som forbindelsesled til ikke-voldelige dele af verden

Deltagere, der havde oplevet GIM beskrev også otte funktioner og roller, som billeddannelsen havde i deres terapi:

1. Indre billeder som en måde at fortælle på
2. Indre billeder som læring
3. Indre billeder som en måde at håndtere traumer på
4. Indre billeder som form
5. Indre billeder som et rum mellem klient og terapeut
6. Indre billeder som forbindelsesled
7. Indre billeder som en ressource i hverdagen
8. Indre billeder som en hjælp til at fokusere

Kun funktionerne nummer 2, 6 og 7 blev også beskrevet af deltagere, som havde oplevet PITT. Kun én af de fem deltagere havde oplevet PITT udført efter Reddemanns manual. Hun beskrev også Indre billeder som noget, der gør det indre liv synligt (= Indre billeder som form). Mens nogle af GIM deltagerne overvejede om arbejdet med indre billeder kunne bringe noget vanskeligt frem, fandt samtlige de indre billeder meget hjælpsomme, og med hjælp af musikken kunne de mestre frygten. PITT deltagere, der lyttede til manuskript-fastlagte øvelser med indre billeder, evt. på CD, forstod dette som en øvelse, der skulle udføres korrekt, og enkelte var bange for ikke at kunne gennemføre det efter reglerne. De sagde også, at de ikke forstod formålet med de indre billeder i deres terapisesessioner. Mens alle GIM deltagerne, og den PITT deltager, der oplevede PITT udført efter Reddemanns manual, så arbejdet med indre billeder som en væsentlig del af deres behandling, som de ikke kunne have undværet, sagde de øvrige PITT deltagere, at det ikke ville have gjort nogen forskel, hvis indre billeder ikke var blevet anvendt i deres terapi.

Deltagere fra begge grupper rapporterede følgende terapeutiske indstillinger og adfærd hos terapeuten som en hjælp:

1. Den terapeutiske relation og dens udvikling blev diskuteret
2. Begge parter søgte kreativt efter løsninger på deltagerens problemer
3. Klarhed og gennemsigtighed hos terapeuten
4. Terapeuten indrømmer at han / hun ikke ved noget, og dette fører til fælles refleksion over problemet
5. En holdende, omsorgsfuld, omhyggelig og støttende indstilling hos terapeuten
6. Terapeuten skal forstå sig selv som model, men på en måde, så patienten ikke føler det er noget hun skal leve op til
7. Anerkendelse af traumerne og dens virkninger
8. Terapeuten tager den overlevendes parti (at indtage en 'neutral' holdning til vold betyder reelt at terapeuten tager gerningsmandens parti)
9. Terapeuten skal være i stand til at rumme patientens indre pres og ambivalens ift den terapeutiske relation
10. Terapeuten overholder princippet om fortrolighed
11. Terapeuten er en ekstern observatør
12. Terapeuten støtter patienten ift problemer i hverdagen.
13. Patienten ved, at hun kan komme tilbage til terapeuten efter at terapien er afsluttet.

Deltagere fra begge grupper rapporterede følgende terapeutiske indstillinger og adfærd hos terapeuten som forhindringer i processen:

1. Overbeskyttende terapeut
2. Power-spil, magtkampe
3. Ureflekterede dobbelte relationer eller misbrug af samme
4. Dumme interventioner (for eksempel "Lad være med at dissociere!").

5. Beskyldninger (dissociation eller frygt bruges til manipulation, osv.)
6. Terapeuten undervurderer betydningen af sin egen person i terapien
7. Terapeuten sagde ikke ret meget. Det fik deltageren til at føle sig alene og usikker på, hvad hun skulle gøre eller sige
8. Terapeuten var for esoterisk og havde ikke jordforbindelse nok. Dette blev oplevet som forvirrende og uden klarhed eller forankring i virkeligheden.
9. Terapeuten sad direkte overfor deltageren. Denne placering gav ikke deltageren mulighed for selv at bestemme, hvor hun skulle se hen
10. Liggende position i psykoanalyse. Det er interessant at bemærke, at selvom deltageren ikke kunne ligge ned i analysen, havde hun ingen problemer med at ligge ned i GIM. Hun vidste ikke hvorfor det var sådan
11. terapeuten troede ikke på deltagerens fortællinger om traumet
12. Længere perioder med terapeutens ferie eller fravær fra arbejde
13. At skulle gå fra en session med følelsen af at være "vendt på hovedet".
14. Ikke at kunne løse problemerne med terapeuten. Dette kunne skyldes både terapeuten og deltageren.

Diskussion

Den betydelige forbedring i forhold til målte symptomer på traume-relaterede lidelser mellem a) GIM gruppen og kontrolgruppen, b) mellem PITT gruppen og kontrolgruppen stemte overens med resultater af andre undersøgelser med GIM eller PITT for traume-overlevende. Den signifikant større forbedring hos deltagere, der fik GIM i forhold til PITT var derimod en overraskelse. Forskellen kan imidlertid skyldes den kendsgerning, at PITT sandsynligvis ikke blev praktiseret ifølge Reddemanns manual. Hvis indre billeder var blevet anvendt i PITT på en friere og mere individualiseret måde, ville resultaterne sandsynligvis have været bedre.

Den kvalitative del af undersøgelsen viser, at indre billeder i både GIM og PITT kan bruges som en form for læring, som psykologisk forbindelsesled og som en coping-

ressource i traumatiserede kvinders hverdagsliv. I PITT fokuseres der udelukkende på selv-beroligelse og på ressourcer, mens fokus i GIM er bredere. I GIM bruges indre billeder som form, som et særligt rum mellem patient og terapeut, som en måde at tale på, og som en hjælp til at fokusere. Billeddannelsens funktioner som ressource i hverdagslivet og som en måde at tale på har ingen paralleller i musikkens roller. Disse funktioner kan mao. kun ivaretages af indre billeder.

På den anden side har også musikken unikke roller. Disse er musik som relation, musik som beholder, og musik som tilvejebringer og fremkalder af indre billeder. Der er også roller, som både indre billeder og musik har i GIM, men de er nærmest komplementære. Både musik og indre billeder kan bruges som læring, men her fungerer musikken som en lærer der sætter ting på dagsordenen, mens de indre billeder giver mulighed for at prøve tingene af. Både musik og indre billeder kan bruges som form, men hvor indre billeder er en meget konkret form, er musik snarere en abstrakt form, eller en form-mulighed. Det samme gælder musik og indre billeder som forbindelsesled: I de indre billeder skabes konkrete relationer, mens musikken tilbyder mere abstrakte, potentielle og indirekte muligheder for relation. Både musik og indre billeder kan skabe rum. Her er det nærmest omvendt: musik skaber et konkret rum, hvor mange ting er mulige – rum, hvor indre billeder kan tage form. Billeddannelse er også rum, men på en mere abstrakt og skjult måde. Først og fremmest skaber billeddannelsen et rum, hvor overføringen kan komme til udtryk. Det samme gælder for musik og indre billeder som hjælper. Musik kan opleves som en tredje person i rummet der aktivt hjælper patienten. Billeddannelsen er mere en indirekte og abstrakt hjælp til at fokusere, til at holde sig til den historie og de emner, der behandles i sessionen.

Brugen af musik synes i væsentlig grad at øge effekten af billeddannelses-baseret traumeterapi. Teorier om musik som selv-objekt, f.eks. Kohuts Selv-Psykologi (Kohut 1984) eller Sterns teori om vitalitetdynamik (Stern 2010) vil kunne fungere som teoretisk baggrundsforståelse.

Symptomerne hos deltagerne i kontrolgruppen forværredes gennem den lange ventetid. Mennesker med Komplex PTSD kan kompensere i et stykke tid, hvis der ikke forekommer væsentlige ændringer i deres liv, og så længe de stadig er stærke nok. Hvis de står over for flere udløsende faktorer, og derfor oplever flashbacks oftere, kan de søge behandling. Hvis hjælpen ikke er forhånden på disse tidspunkter, kan deres tilstand forværres. Det faktum, at de (igen) ikke blev hjulpet, kan også være en ny trigger, som kan fremkalde flere flashbacks i tillæg til de allerede eksisterende.

Begrænsninger i undersøgelsens resultater er dels min egen position som både traumepatient, terapeut og forsker, dels det faktum, at deltagerne forskellige nationaliteter ikke matcher deres gruppetilhørsforhold, og endelig at jeg aldrig selv har oplevet PITT. Derfor kunne jeg kun bruge den heuristiske metode ift GIM, men ikke ift PITT. Undersøgelsen er også begrænset til klientens perspektiv og til kvindelige patienter.

Det ville være værdifuldt at gentage den empiriske del af undersøgelsen med en mere homogen deltagergruppe (forskere og patienter) ift nationalt tilhørsforhold. En tilsvarende undersøgelse med mandlige deltagere ville kunne vise, om der er kønsforskelle eller ej. Yderligere forskning vil også være nødvendigt for at opnå mere viden om konsekvenserne af at vente på terapi, og om hvornår og til hvilke typer traumatiserede patienter brugen af musik i terapi er nyttig. Og endelig er mere grundforskning nødvendig til at opbygge teorier om traumer og indikeret traumebehandling.

Konklusion

Undersøgelsen indikerer, at både GIM og PITT har potentiale til markant at forbedre symptomer på Komplex PTSD og at mindske dissociation, lindre interpersonelle problemer og styrke faktorer, der fremmer sundheden hos alvorligt traumatiserede kvinder. GIM og modificeret GIM viste sig at være betydeligt mere effektiv end PITT. Dette kan skyldes brugen af musik og / eller den mere individualiserede praksis i GIM.

Musikken i billeddannelsesbaseret traumeterapi kan anvendes som selv-objekt, og den tilbyder desuden vitalitetsformer, som traumatiserede patienter kan anvende til forbedret fysisk og psykiske velbefindende.

Oversættelse: Lars Ole Bonde

REFERENCES

- Abrams, B. (2002). Definitions of Transpersonal BMGIM Experiences. Nordic Journal of Music Therapy, 11(2), p. 103-126.
- American Psychiatric Association (1994). Desk reference to the Diagnostic Criteria from DSM-IV. Washington: American Psychiatric Association.
- Antonovsky, A. (1987). Unraveling the Mystery of Health: How People Manage Stress and Stay Well. San Francisco: Jossey-Bass.
- Association for Music and Imagery (1992). Definition of the Bonny Method of Guided Imagery and Music (BMGIM). AMI, P.O. Box 4286, Blain, WA 98231-42286, USA.
- Bass, E. & Davis, L. (1994). The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse. New York: HarperCollins Publishers.
- Bauer, J. (2006). Warum ich fühle, was du fühlst:: Intuitive Kommunikation und das Geheimnis der Spiegelneurone. Hamburg: Hoffmann und Campe.
- Belland, J.R. (1994). The Bonny Method of Guided Imagery and Music: A Review of the Practice through Case Reports. Unpublished master's thesis, Hahnemann University, Philadelphia, Pennsylvania, USA.
- Birck, A. (2001). Die Verarbeitung sexualisierter Gewalt in der Kindheit bei Frauen in der Psychotherapie. Berlin: Behandlungszentrum für Folteropfer.
- Blake, R.L. (1994). Vietnam Veterans with Post Traumatic Stress Disorder: Findings from a Music and Imagery Project. Journal of the Association for Music and Imagery, 3, p. 5-18.
- Blake, R.L. & Bishop, S.R. (1994). The Bonny Method of Guided Imagery and Music in the Treatment of Post-Traumatic Stress Disorder with Adults in the Psychiatric Setting. Music Therapy Perspectives, 12, p. 125-129.

Bond, G., Bloch, S. & Yalom, I.D. (1979). The Evolution of a "Target Problem" Approach to Outcome Measurement. Psychotherapy: Theory, Research and Practice, 16, p. 48-54.

Bonde, L.O. (2005). The Bonny Method of Guided Imagery and Music (BMGIM) with Cancer Survivors: A Psychosocial Study with Focus on the Influence of BMGIM on Mood and Quality of Life. Dissertation, Aalborg University, Denmark.

Bonny, H.L. (1978). GIM Monograph #1: Facilitating GIM Sessions. Salina, KS: Bonny Foundation.

Bonny, H.L. (1994). Twenty-one Years Later: A GIM Update. Music Therapy Perspectives, 12, p. 70-74.

Bonny, H.L. & Pahnke, W.N. (1972). The Use of Music in Psychedelic (LSD) Psychotherapy. Journal of Music Therapy, IX, p. 64-87.

Brand et al. (2009). A Review of Dissociative Disorders Treatment Studies. The Journal of Nervous and Mental Disease, 197(9), p. 646-654.

Braun, B. (1988). The BASK model of dissociation: Clinical applications. Dissociation 1, 2, p. 4-23.

Brewin, C.R. (2003). Posttraumatic Stress Disorder: Malady or Myth? New Haven, London: Yale University Press.

Bruscia, K.E. (1995). Manifestations of Transference in Guided Imagery and Music. Journal of the Association for Music and Imagery, 4, p. 17-36.

Bruscia, K.E. (ed.) (1998), The Dynamics of Music Psychotherapy. Gilsum: Barcelona Publishers.

Bruscia, K.E. (2002a). The Boundaries of Guided Imagery and Music and the Bonny Method. In: K.E. Bruscia & D.E. Grocke (eds.), Guided Imagery and Music: The Bonny Method and Beyond. Gilsum: Barcelona Publishers.

Bruscia, K.E. (2002b). A Psychodynamic Orientation to the Bonny Method. In: K.E. Bruscia & D.E. Grocke (eds.), Guided Imagery and Music: The Bonny Method and Beyond. Gilsum: Barcelona Publishers.

Bruscia, K.E. (2005). First-person Research. In: B.L. Wheeler (ed.), Music Therapy Research: Second Edition. Gilsum: Barcelona Publishers.

Bruscia, K.E. & Grocke, D.E. (Eds.) (2002). Guided Imagery and Music: The Bonny Method and Beyond. Gilsum: Barcelona Publishers.

Buhrmester, E.C. (2008). Personal communication.

Bush, C. & Stokes, S. (1999). Level II Course Material. Virginia Beach, VA: Mid-Atlantic GIM Training Institute.

Calhoun, L.G. & Tedeschi, R.G. (1999). Facilitating Posttraumatic Growth: A Clinician's Guide. Mahwah: Lawrence Erlbaum Associates.

Cloitre, M. (2009). Effective Psychotherapies for Posttraumatic Stress Disorder: A Review and Critique. CNS Spectrum, 14(1), p. 32-43.

Creamer, M., Burgess, P.M. & McFarlane, A.C. (2001). Posttraumatic Stress Disorder: Findings from the Australian National Survey of Mental Health and Well-Being. Psychological Medicine, 31(7), p. 1237-1247.

Davis, L. (1991). Allies in Healing: When the Person You Love Was Sexually Abused as a Child. New York, London, Toronto, Sydney: Harper.

Dilling, H., Mombour, W. & Schmidt, M.H. (Eds.) (1995). Internationale Klassifikation psychischer Störungen: ICD-10 Kapitel V (F) Klinisch-diagnostische Leitlinien. Bern, Göttingen, Toronto, Seattle: Verlag Hans Huber.

Dorrepaal, E., Thomaes, K. & Draijer, P.J. (2006). Stabilisatiecursus als antwoord op complexe posttraumatische stressstoornis: Diagnostiek, behandeling en onderzoek bij vroeggetraumatiseerde vrouwen met een complexe posttraumatische stressstoornis. Tijdschrift voor Psychiatrie, 48, p. 217-222.

Douglas, B. & Moustakas, C. (1985). Heuristic Inquiry: The Internal Search to Know. Journal of Humanistic Psychology, 25(3), p. 39-55.

Draguns, J.G. (1997). Ethnocultural Considerations in the Treatment of PTSD: Therapy and Service Delivery. In: A.J. Marsella, M.J. Friedman, E.T. Gerrity & R.M.

Scurfield (eds.), Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research, and Clinical Applications. Washington: American Psychological Association.

Eriksson, M. & Lindström, B. (2005). Validity of Antonovsky's Sense of Coherence Scale: a Systematic Review. Journal of Epidemiology and Community Health, 59, 460-466.

Fischer, G. (2000). KÖDOPS: Kölner Dokumentationssystem für Psychotherapie und Traumabehandlung. Köln: Verlag Deutsches Institut für Psychotraumatologie (DIPT).

Fischer, G. & Riedesser, P. (1999). Lehrbuch der Psychotraumatologie, 2nd edition. München, Basel: Ernst Reinhardt Verlag.

Fiske, D.W. (1975). A Source of Data is not a Measuring Instrument. Journal of Abnormal Psychology, 84(1), p. 20-23.

Foa, E.B. & Meadows, E.A. (1997). Psychosocial Treatments for Posttraumatic Stress Disorder: A Critical Review. Annual Reviews Psychology, 48, p. 449-480.

Forinash, M. & Grocke, D. (2005). Phenomenological Inquiry. In : B.L. Wheeler (ed.), Music Therapy Research: Second Edition. Gilsum: Barcelona Publishers.

Gahleitner, S.-B. (2001). Ways of Combining Qualitative and Quantitative Procedures Exemplified in a Study on the Gender-Specifics of Coping with Sexual Violence. In: M. Kiegelmann (ed.), Qualitative Research in Psychology, Vol. 1. Schwangau: Ingeborg Huber.

Gahleitner, S.-B. (2003). Gender-Specific Aspects of Coming to Terms with Sexual Abuse: Results of a Qualitative Study. In: M. Kiegelmann & L. Gürtler (Eds.). Research Questions and Matching Methods of Analysis: Qualitative Research in Psychology, Vol. III (p. 171-182). Schwangau: Ingeborg Huber.

Gahleitner, S.-B. (2004). Geschlechtsspezifische Verarbeitung sexueller Gewalt: Eine explorative Untersuchung aus salutogenetischer Perspektive. Internet: <http://www2.huberlin.de/ffz/pdf-files/gahleitner.pdf>.

Garfield, S.L., Prager, R.A., & Bergin, A.E. (1971). Evaluation of Outcome in Psychotherapy. Journal of Consulting and Clinical Psychology, 37(3), 307-313.

Geiger, E.M. (2004). GIM – The Bonny Method of Guided Imagery and Music: Imaginative Psychotherapie mit Musik nach Helen Bonny. In: I. Frohne-Hagemann (ed.), Rezeptive Musiktherapie: Theorie und Praxis. Wiesbaden: Reichert Verlag.

Geiger, E.M. (2007). The Guide-Traveler Relationship in BMGIM as a Developmental Relationship for the Self (D. Stern): Exploring the Parallels between the Early Mother-Infant-Relationship and the Relationship between Traveler and Guide. In: I. Frohne-Hagemann (ed.), Receptive Music Therapy: Theory and Practice. Wiesbaden: Reichert Verlag.

Geiger, E.M. & Maack, C. (2010). Lehrbuch Guided Imagery and Music (GIM). Wiesbaden: Reichert Verlag.

Gold, C., Solli, H.P., Krüger, V., & Lie, S.A. (2009). Dose–Response Relationship in Music Therapy for People with Serious Mental Disorders: Systematic Review and Meta-Analysis. Clinical Psychology Review, 29(3), p. 193–207.

Goldberg, F.S. (1992). Images of Emotions: The Role of Emotions in Guided Imagery and Music. Journal of the Association for Music and Imagery, 1, p. 5-17.

Goldberg, F.S. (1994). The Bonny Method of Guided Imagery and Music as Individual and Group Treatment in a Short-Term Acute Psychiatric Hospital. Journal of the Association for Music and Imagery, 3, p. 18-33.

Goldberg, F.S. (2002). A Holographic Field Theory Model of the Bonny Method of Guided Imagery and Music (BMGIM). In: K.E. Bruscia & D.E. Grocke (Eds.), Guided Imagery and Music: The Bonny Method and Beyond. Gilsum: Barcelona Publishers.

Goldberg, F. (2004). Unpublished Training Material. Therapeutic Arts.

Greenberg, L.S. & Pinsof, W.M. (1986). Process Research: Current Trends and Future Perspectives. In: L.S. Greenberg & W.M. Pinsof (eds.), The Psychotherapeutic Process: A Research Handbook. New York: Guildford Press.

Grocke, D.E. (1999a). A Phenomenological Study of Pivotal Moments in Guided Imagery and Music (GIM) Therapy. Doctoral Dissertation. Melbourne: Faculty of Music, The University of Melbourne.

Grocke, D.E. (1999b). Pivotal Moments in Guided Imagery and Music. In: J. Hibben (ed.), Inside Music Therapy: Client Experiences. Gilsum: Barcelona Publishers.

Grocke, D.E. (2002a). The Evolution of Bonny's Music Programs. In: K.E. Bruscia & D.E. Grocke (Eds.), Guided Imagery and Music: The Bonny Method and Beyond. Gilsum: Barcelona Publishers.

Grocke, D.E. (2002b). Richtungsweisende Momente in „Guided Imagery and Music“ (GIM). Musiktherapeutische Umschau, 23(3), p. 246-258.

Gurman, A.S. & Kniskern, D.P. (1981). Family Therapy Outcome Research: Knowns and Unknowns. In: A.S. Gurman & D.P. Kniskern (eds.), Handbook of Family Therapy. New York: Brunner & Mazel.

Hansen, D. (1999). Traumatisierung von Frauen durch Gewalt: Folgen singulärer Viktimisierung im Vergleich zu denen sequentieller Viktimisierung. Hamburg: Verlag Dr. Kovac.

Harper, K., Stalker, C.A., Palmer, S. & Gadbois, S. (2008). Adults traumatized by Child Abuse: What Survivors Need from Community-Based Mental Health Professionals. Journal of Mental Health, 17(4), p. 361-374.

Herman, J.L. (1998). Trauma and Recovery : From Domestic Abuse to Political Terror. London: Pandora.

Hofstede, G. & Bond, M.H. (1988). The Confucius Connection: From Cultural Roots to Economic Growth. Organizational Dynamics, 16(4), p. 4-21.

Hüther, G. (2004a). Die Macht der inneren Bilder: Wie Visionen das Gehirn, den Menschen und die Welt verändern. Göttingen: Vandenhoeck & Ruprecht.

Hüther, G. (2004b). Ebenen salutogenetischer Wirkung von Musik auf das Gehirn. Musiktherapeutische Umschau, 25(1), p. 16-26.

Hüther, G. (2004c). Biologie der Angst: Wie aus Streß Gefühle werden. Göttingen: Vandenhoeck & Ruprecht.

Huber, M. (1997). Multiple Persönlichkeiten: Überlebende extremer Gewalt. Frankfurt: Fischer.

Huber, M. (2003). Trauma und Traumabehandlung Teil 1: Trauma und die Folgen. Paderborn: Junfermann Verlag.

Hughes, J. & Barkham, M. (2005). Scoping the Inventory of Interpersonal Problems, its Derivatives and Short forms: 1988–2004. *Clinical Psychology & Psychotherapy*, 12 (6), 475-496.

Isenberg-Grzeda, C. (1998). Transference Structures in Guided Imagery and Music. In: K.E. Bruscia (ed.), The Dynamics of Music Psychotherapy. Gilsum: Barcelona Publishers.

Isenberg-Grzeda, C. (1999). Experiencing the Music in Guided Imagery and Music. In: J. Hibben (ed.), Inside Music Therapy: Client Experiences. Gilsum: Barcelona Publishers.

Janssen, I., Krabbendam, I., Hanssen, M., Bak, M., Vollenbergh, W., de Graaf, R. et al. (2005). Are Apparent Associations Between Parental Representations and Psychosis Risk Mediated by Early Trauma? *Acta Psychiatrica Scandinavica*, 112, p. 372-375.

Josephson, B.D. & Carpenter, T. (1994). What Can Music Tell Us about the Nature of the Mind? A Platonic Model. Paper presented at the conference “Toward a Scientific Basis for Consciousness”, held at the University of Arizona, Tucson.

Keane, T.M. (1998). Psychological and Behavioral Treatments of Post-Traumatic Stress Disorder. In: P.E. Nathan & J.M. Gorman et al. (Eds.), A Guide to Treatments that Work. New York: Oxford University Press.

Kenny, C., Jahn-Langenberg, M. & Loewy, J. (2005). Hermeneutic Inquiry. In : B.L. Wheeler (ed.), Music Therapy Research: Second Edition. Gilsum: Barcelona Publishers.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M. & Nelson, C.B. (1995). Posttraumatic Stress Disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52, p. 1048-1060.

Kim, Y. & Pilkonis, P.A. (1999). Selecting the Most Informative Items in the IIP Scales for Personality Disorders: An Application of Item Response Theory. Journal of Personality Disorders, 13(2), p. 157-174.

Kluft, R.P., Bloom, S.L. & Kinzie, J.D. (2000). Treating the Traumatized Patient and Victims of Violence. In: C.C. Bell (Ed.), Psychiatric Aspects of Violence: Issues in Prevention and Treatment: New Directions in Mental Health Services, 86, p. 79-102.

Kohut, H. (1984). How Does Analysis Cure? Chicago: University of Chicago Press.

Körlin, D. (2002). A Neuropsychological Theory of Traumatic Imagery in the Bonny Method of Guided Imagery and Music (BMGIM). In: K.E. Bruscia & D.E. Grocke (Eds.), Guided Imagery and Music: The Bonny Method and Beyond. Gilsum, NH: Barcelona Publishers.

Körlin, D. (2008). Music Breathing: Breath Grounding and Modulation of the Bonny Method of Guided Imagery and Music (BMGIM): Theory, Method, and Consecutive Cases. Journal of the Association for Music and Imagery, 11, 79-113.

Körlin, D., Nybäck, H. & Goldberg, F.S. (2000). Creative Arts Groups in Psychiatric Care: Development and Evaluation of a Therapeutic Alternative. Nordic Journal of Psychiatry, 55, p. 333-340.

Körlin, D. & Wrangsjö, B. (2001). Gender Differences in Outcome of Guided Imagery and Music (GIM) Therapy. Nordic Journal of Music Therapy, 10(2), p. 132-143

Körlin, D. & Wrangsjö, B. (2002). Treatment Effects of GIM Therapy. Nordic Journal of Music Therapy, 11(1), p. 3-15.

Körlin, D., Edman, G. & Nybäck, H. (2005). Screening for Dissociation: Reliability and Validity of a Swedish Version of the Dissociative Experience Scale (DES-II). In: D. Körlin, Creative Arts Therapies in Psychiatric Treatment: A Clinical Application of the Bonny Method of Guided Imagery and Music (BMGIM) and Creative Arts Groups. Stockholm: Kongl Carolinska Medico Chirurgiska Institutet.

Lampe, A. , Mitmansgruber, H., Gast, U., Schüssler, G. & Reddemann, L. (2008). Therapieevaluation der Psychodynamisch Imaginativen Traumatherapie (PITT) im stationären Setting. Neuropsychiatrie, 22(3), p. 189-197.

Lankoff, G. & Johnson, M. (1980). Metaphors We Live By. Chicago: The University of Chicago Press.

Lansen, J. & Haans, T. (2004). Clinical Supervision for Trauma Therapists. In: J.P. Wilson & B. Drozdek (eds.), Broken Spirits: The Treatment of Traumatized Asylum Seekers, Refugees, War and Torture Victims. New York, Hove: Brunner-Routledge.

Leuner, H. (1974). Die Bedeutung der Musik in imaginativen Techniken der Psychotherapie. In: W.J. Revers, G. Harrer & W.C.M. Simon (eds.), Neue Wege der Musiktherapie. Düsseldorf & Wien: Econ Verlag.

Leuner, H. & Wilke, E. (2011). Katathym-imaginative Psychotherapie (KiP). Stuttgart: Thieme.

Loewenstein, R.J. & Welzant, V. (2010). Pragmatic Approaches to Stage-Oriented Treatment for Early Life Trauma-Related Complex Post-Traumatic Stress and Dissociative Disorders. In: R.A. Lanius, E. Vermetten & C. Pain (eds.), The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic. Cambridge: Cambridge University Press.

Luborsky, L. et al. (1999). The Researcher's Own Therapy Allegiance: A "Wild Card" in Comparisons of Treatment Efficacy. Clinical Psychology: Science and Practice, 6(1), p. 95-106.

Luxenburg, T., Spinazzola, J. & van der Kolk, B.A. (2001a). Complex Trauma and Disorders of Extreme Stress (DESNOS) Diagnosis Part One: Assessment. Directions in Psychiatry, 21, p. 373-392.

Luxenburg, T., Spinazzola, J., Hidalgo, J., Hunt, C. & van der Kolk B.A. (2001b). Complex Trauma and Disorder of Extreme Stress (DESNOS) Part Two: Treatment. Directions in Psychiatry, 21, p. 395-414.

Maack, C. (2004a). Rezeptive Musiktherapie als Psychotherapie für Menschen mit Persönlichkeitsstörungen. In: T. Timmermann (Ed.), Empfinden – Hören – Sehen: Welche Zugänge wählen nonverbale Psychotherapien? Am Beispiel der Diagnose: Persönlichkeitsstörung. Wiesbaden: Reichert Verlag.

Maack, C. (2004b). Kulturelle Aspekte in der Arbeit mit rezeptiver Musiktherapie am Beispiel von Guided Imagery and Music nach Helen Bonny (GIM). In: I. Frohne-Hagemann (ed.), Rezeptive Musiktherapie: Theorie und Praxis. Wiesbaden: Reichert Verlag.

Maack, C. (2006). The Bonny Method of Guided Imagery and Music (BMGIM) and its Adaptations in Psychotherapy for Patients with Complex Posttraumatic Stress Disorder. Presentation at the Australasian Music & Imagery Conference 2006, Auckland, New Zealand.

Maercker, A. & Zoellner, T. (2004). The Janus Face of Self-Perceived Growth: Toward a Two-Component Model of Posttraumatic Growth. Psychological Inquiry, 15(1), p. 41-48.

Meadows, A. (2002). Distinctions between the Bonny Method of Guided Imagery and Music (BMGIM) and Other Imagery Techniques. In: K.E. Bruscia & D.E. Grocke (Eds.), Guided Imagery and Music: The Bonny Method and Beyond. Gilsum, NH: Barcelona Publishers.

Moser, T. (1995). Psychoanalyse und Macht: Über das Auftauchen von NS-Zeit, Stalinismus und Krieg in der Therapie. In: C.J. Schmidt-Lellek & B. Heimannsberg (eds.), Macht und Machtmissbrauch in der Psychotherapie. Köln: Edition Humanistische Psychologie.

Moustakas, C. (1990). Heuristic Research: Design, Methodology, and Application. Newbury Park, London, New Delhi: Sage Publications.

National Collaborating Centre for Mental Health (2005). Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. London: Gaskell and the British Psychological Society.

Nijenhuis, E.R.S. (2003). The Scoring and Interpretation of the SDQ-20 and SDQ-5: Update 2003. Assen: Mental Health Care Drenthe.

Nijenhuis, E.R.S., Spinhoven, P., Van Dyck, R., Van der Hart, O., & Vanderlinden, J. (1996). The Development and the Psychometric Characteristics of the Somatoform Dissociation Questionnaire (SDQ-20). Journal of Nervous and Mental Disease, 184, 688-694.

Nijenhuis, E.R.S., Spinhoven, P., Van Dyck, R., Van der Hart, O., De Graaf, A.M.J., & Knoppert, E.A.M. (1997a). Dissociative pathology discriminates between bipolar mood disorder and dissociative disorder. British Journal of Psychiatry, 170, p. 581.

Nijenhuis, E.R.S., Spinhoven, P., Van Dyck, R., Van der Hart, O., & Vanderlinden, J. (1997b). The development of the Somatoform Dissociation Questionnaire (SDQ-5) as a screening instrument for dissociative disorders. Acta Psychiatrica Scandinavica, 96, p. 311-318.

Nijenhuis, E.R.S., Spinhoven, P., Vanderlinden, J., Van Dyck, R., & Van der Hart, O. (1998a). Somatoform dissociative symptoms as related to animal defensive reactions to predatory threat and injury. Journal of Abnormal Psychology, 107, p. 63-73.

Nijenhuis, E.R.S., Spinhoven, P., Van Dyck, R., Van der Hart, O., & Vanderlinden, J. (1998b). Psychometric characteristics of the Somatoform Dissociation Questionnaire: A replication study. Psychotherapy & Psychosomatics, 67, p. 17-23.

Nijenhuis, E.R.S., van der Hart, O. & Steele, K. (2004). Trauma-related Structural Dissociation of the Personality. Trauma Information Pages website, January 2004. Web URL: <http://www.trauma-pages.com/nijenhuis-2004.htm>.

Nolen-Hoeksema, S. & Davis, C.G. (2004). Theoretical and Methodological Issues in the Assessment and Interpretation of Posttraumatic Growth. Psychological Inquiry, 15(1), p. 60-64.

Pain, C., Lanius, R.A., Ogden, P. & Vermetten, E. (2010). Psychodynamic Psychotherapy: Adaptations for the Treatment of Patients with Chronic Post-Traumatic Stress Disorder. In: R.A. Lanius, E. Vermetten & C. Pain (eds.), The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic. Cambridge: Cambridge University Press.

Perry, B.D. (1999). The Memory of States: How the Brain Stores and Retrieves Traumatic Experiences. In: J. Goodwin & R. Attias (Eds.), Splintered Reflections: Images of the Body in Treatment. New York: Basic Books.

Pickett, E. (1992). Using Guided Imagery and Music with a Dually Diagnosed Woman Having Multiple Addictions. Journal of the Association for Music and Imagery, 1, p. 55-67.

Pickett, E. (1995). The Bonny Method of Guided Imagery and Music: A Technique for Healing Trauma. Journal of the Association for Music and Imagery, 4, p. 93-101.

Pickett, E. & Sonnen, C. (1993). Guided Imagery and Music: A Music Therapy Approach to Multiple Personality Disorder. Journal of the Association for Music and Imagery, 2, p. 49-72.

Read, J., van Os, J., Morrison, A.P. & Ross, C.A. (2005). Childhood Trauma, Psychosis and Schizophrenia: A Literature Review with Theoretical and Clinical Implications. Acta Psychiatrica Scandinavica, 112, p. 330-350.

Reddemann, L. (2001). Imagination als heilsame Kraft: Zur Behandlung von Traumafolgen mit ressourcenorientierten Verfahren. Stuttgart: Pfeiffer bei Klett-Cotta.

Reddemann, L. (2003). Die psychodynamisch imaginative Traumatherapie (PITT). Zeitschrift für Psychotraumatologie und Psychologische Medizin, 1(2), p. 1-8.

Reddemann, L. (2004). Psychodynamisch Imaginative Traumatherapie: PITT – Das Manual. Stuttgart: Pfeiffer bei Klett-Cotta.

Reddemann, L. (2006). Psychodynamische Therapie traumainduzierter Störungen. Presentation held at the “8. Jahrestagung der Deutschsprachigen Gesellschaft für Psychotraumatologie (DeGPT)”, Hannover.

Rinker, R.L. (1991). Guided Imagery and Music (GIM): Healing the Wounded Healer. In: K.E. Bruscia (ed.), Case Studies in Music Therapy. Phoenixville: Barcelona Publishers.

Robson, C. (2002). Real World Research: Second Edition. Malden, Oxford, Victoria: Blackwell Publishing.

Sachsse, U., Vogel, C. & Leichsenring, F. (2006). Results of Psychodynamically Oriented Trauma-focused Inpatient Treatment for Women with Complex Posttraumatic Stress Disorder (PTSD) and Borderline Personality Disorder (BPD). Bulletin of the Menninger Clinic, 70(2), p. 125-144.

Sand, S. & Levin, R. (1992). Music and Its Relationship to Dreams and the Self. Psychoanalysis and Contemporary Thought, 15, p. 161-197.

Schore, A.N. (2001). The Effects of Early Relational Trauma on Right Brain Development, Affect Regulation, and Infant Mental Health. Infant Mental Health Journal, 22, p. 201-269.

Schottenbauer, M.A. et al. (2008). Nonresponse and Dropout Rates in Outcome Studies on PTSD: Review and Methodological Considerations. Psychiatry: Interpersonal & Biological Processes, 71(2), p. 134-168.

Schumacher, J. & Brähler, E. (2000). Sense of Coherence Scale von Antonovsky (SOC-Skala). Internet: <http://joerg-schumacher.net/test.html>.

Siegel, D.J. (1999). The Developing Mind: Toward a Neurobiology of Interpersonal Experience. New York, London: Guilford Press.

Siegel, D.J. (2007). The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being. New York, London: Norton.

Siegelmann, E.Y. (1990). Metaphor and Meaning in Psychotherapy. New York: Guildford Press.

Snekkevik, H., Anke, A.G.W., Stanghelle, J.K. & Fugl-Meyer, A.R. (2003). Is Sense of Coherence Stable after Multiple Trauma? Clinical Rehabilitation, 17(4), 443-452.

Spinazzola, J., Blaustein, M. & van der Kolk, B.A. (2005). Posttraumatic Stress Disorder Treatment Outcome Research: The Study of Unrepresentative Samples? Journal of Traumatic Stress, 18(5), p. 425-435.

Stanton, A.L. & Low, C.A. (2004). Toward Understanding Posttraumatic Growth: Commentary on Tedeschi and Calhoun. Psychological Inquiry, 15(1), p. 76-80.

Steele, K., van der Hart, O. & Nijenhuis, E.R.S. (2001). Dependency in the Treatment of Complex Posttraumatic Stress Disorder and Dissociative Disorders. Journal of Trauma and Dissociation, 2(4), p. 79-116.

Stern, D.N. (2000). The Interpersonal World of the Infant: A View from Psychoanalysis & Developmental Psychology. New York: Basic Books.

Stern, D.N. (2010a). Forms of Vitality: Exploring Dynamic Experience in Psychology, the Arts, Psychotherapy, and Development. Oxford: Oxford University Press.

Stern, D.N. (2010b). The Issue of Vitality. Nordic Journal of Music Therapy, 19(2), p. 88-102.

Strupp, H.H. & Hadley, S.W. (1977). A Tripartite Model of Mental Health and Therapeutic Outcomes. American Psychologist, 32, p. 187-196.

Summer, L. (1990). Guided Imagery and Music in the Institutional Setting, 2nd edition. Missouri: MMB.

Summer, L. (1995). Melding Musical and Psychological Processes: The Therapeutic Musical Space. Journal of the Association for Music and Imagery, 4, p. 37-48.

Summer, L. (1998). The Pure Music Transference in Guided Imagery and Music. In: K.E. Bruscia (ed.), The Dynamics of Music Psychotherapy. Gilsum: Barcelona Publishers.

Summer, L. (2001). The Triadic Relationship: Client, Therapist, Music. Unpublished Course Material. San Francisco: Therapeutic Arts Institute.

Tasney, K. (1993). Beginning the Healing of Incest through Guided Imagery and Music: A Jungian Perspective. Journal of the Association for Music and Imagery, 2, p. 35-47.

Tedeschi, R.G. & Calhoun, L.G. (2004a). Posttraumatic Growth: Conceptual Foundation and Empirical Evidence. Psychological Inquiry, 15(1), p. 1-18.

Tedeschi, R.G. & Calhoun, L.G. (2004b). Posttraumatic Growth: A New Perspective on Psychotraumatology. Psychiatric Times, XXI(4), p. 1-4.

Toomey, L. (1997). Literature Review. Journal of the Association for Music and Imagery, 5, p. 75-103.

Trauma Center (2003). Trauma Center Assessment Package. Brooklin: Trauma Center.

Traumaprojekt Hamburg (2012). Strukturell Analytische Traumatherapie (SATT): Eine Kurzdarstellung. Unpublished manuscript.

Van der Hart, O., Nijenhuis, E.R.S. & Steele, K. (2006). The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization. New York, London: Norton & Company.

Van der Kolk, B.A. (1994). The Body Keeps the Score: Memory and the Evolving Psychobiology of Posttraumatic Stress. Harvard Review of Psychiatry, 1, p. 253-265.

Van der Kolk, B., Pelcovitz, D., Roth, S., Mandel, F., McFarlane, A. & Herman, J.L. (1996). Dissociation, Somatization, and Affect Dysregulation: The Complexity of Adaptation to Trauma. American Journal of Psychiatry, 153 (7), 83-93.

Van der Kolk, B.A., van der Hart, O. & Marmar, C.R. (2000). Dissoziation und Informationsverarbeitung beim posttraumatischen Belastungssyndrom. In: B.A. van der Kolk, A.C. McFarlane & L. Weisaeth (eds.), Traumatic Stress: Grundlagen und Behandlungsansätze. Paderborn: Junfermann Verlag.

Van der Kolk, B.A. (2001). The Assessment and Treatment of Complex PTSD. In: R. Yehuda (Ed.), Traumatic Stress. Washington: American Psychiatric Press.

Van der Kolk, B.A. (2002). SIDES-SR. Brookline: The Trauma Center.

Van der Kolk, B.A., Roth, S., Pelcovitz, D., Sunday, S. & Spinazzola, J. (2005). Disorder of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. Journal of Traumatic Stress, 18, 5, p. 389-399.

Von der Stein, B. (2007). "Blinde Flecken" bei Psychotherapeut(inn)en oder: Missbrauchsfallen in der Psychotherapie. Psychotherapie Forum, 15, p. 122-126.

Wallner, N.G., Putnam, F.W. & Carlson, E.B. (1996). Types of Dissociation and Dissociative Types: A Taxometric Analysis of Dissociative Experiences. Psychological Methods, 1 (3), 300-321.

Wampold, B.E. (2001). The Great Psychotherapy Debate: Models, Methods, and Findings. Mahwah: Lawrence Erlbaum Associates.

Watkins, J.G. & Watkins, H. (1997). Ego States: Theory and Therapy. New York: Norton.

Watson, D. (2003). Investigating the Construct Validity of the Dissociative Taxon: Stability Analysis of Normal and Pathological Dissociation. Journal of Abnormal Psychology, 112, 298-305.

Wilber, K. (1995). Sex, Ecology, Spirituality: The Spirit of Evolution. Boston, London: Shambala.

Wilber, K. (1996). A Brief History of Everything. Boston, London: Shambala.

Wilson, J.P. & Lindy, J.D. (eds.) (1994). Countertransference in the Treatment of PTSD. New York: Guilford.

Wilson, J.P. & Lindy, J.D. (1999). Empathic Strain and Countertransference. In: M.J. Horowitz (ed.), Essential Papers on Posttraumatic Stress Disorder. New York & London: New York University Press.

Wirtz, U. (2003). Die spirituelle Dimension der Traumatherapie. Transpersonale Psychologie und Psychotherapie, p. 4-17.

Wirtz, U. (2006). Flügel trotz allem: Wachstumschancen nach traumatischen Erfahrungen – Vom Guten des Schlechten. Presentation at the conference “Grenzgänge – 20 Jahre Frauen – Sucht – Arbeit”. München: Condrops e.V.

Wrangsjö, B. (1994). Psychoanalysis and Guided Imagery and Music: A Comparison. Journal of the Association for Music and Imagery, 3, p. 35-48.

Wrangsjö, B. & Körlin, D. (1995). Guided Imagery and Music as a Psychotherapeutic Method in Psychiatry. Journal of the Association for Music and Imagery, 4, p. 79-92.